


HEALTHY PEOPLE 2000

A row of blue silhouettes of people of various ages and abilities standing in front of the large number '2000'. The silhouettes include a person in a wheelchair, a person holding a child, and several other individuals of different heights and builds, representing a diverse population.

*Midcourse Review
and 1995 Revisions*



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Preface

This mid-decade review of HEALTHY PEOPLE 2000 shows that the United States is moving in the right direction on more than two-thirds of the national objectives for which we have data. The report demonstrates that partnerships among all levels of government and the private sector continue to make positive differences in people's health. We can celebrate many hopeful trends: Life expectancy continues to increase. Heart disease and stroke deaths continue to decline. Americans are changing their diets to consume less fat and more fruits and vegetables. More women are seeking prenatal care in their first trimesters and are giving their newborns healthy starts by breastfeeding.

However, we still face significant challenges: Americans who have disabilities, come from lower income families, or are members of minority groups continue to experience disproportionately worse health outcomes than other Americans. To reach our vision of Healthy People in Healthy Communities, we must close these gaps.

For 15 years, the Public Health Service has tracked and reported on the health status of Americans in relation to a variety of national health objectives. This work helps to shape America's research agenda, training initiatives, and health delivery system. It helps define the roles and responsibilities of citizens and the public and private sectors in promoting sound health policies and practices. It helps to identify health policies that work in areas as diverse as highway safety, HIV prevention, promotion of healthier diets, and meeting the special needs of children and older Americans.

I commend *Healthy People 2000: Midcourse Review and 1995 Revisions* as an important tool for improving the health of all Americans. Working together, we can build a healthier Nation.

Donna E. Shalala

Secretary of Health and Human Services

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HEALTHY PEOPLE 2000

A graphic element where the year '2000' is rendered in large, blue-outlined numerals. In front of the bottom of these numerals is a row of blue silhouettes of people of various ages and abilities, including a person in a wheelchair, representing the goal of health for all.

Midcourse Review and 1995 Revisions

U.S. Department of Health and Human Services
Public Health Service

HEALTHY

PEOPLE

FOR

ALL

AMERICAN PEOPLE

and 1965 Version

U.S. Department of Health, Education and Welfare

Public Health Service

Foreword

A great deal has been accomplished in the 5 years following the release of *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Americans are living longer; infant mortality is at a record low level; childhood immunizations are increasing; tobacco use is declining; and more women over age 50 are receiving mammograms at recommended intervals. The *Healthy People 2000 Midcourse Review and 1995 Revisions*, the mid-decade report on the Nation's prevention agenda, provides us with this good news. This publication also shows that many challenges remain in preventing premature death and in improving health as the next century approaches.

This report is a call to action. Making a difference in the health of Americans requires renewed effort. The public health system at State and local levels must be strengthened to deliver the services that will keep the population healthy. Finance and payments systems should reward providers and health plans for keeping people healthy. Data systems must be put into place and maintained to provide information on emerging diseases, on the adequacy of child or adult immunizations, and on current utilization of clinical preventive services that are cost-effective and can save lives. Translating this information into public policies promoting health and into information people can use to choose healthy lifestyles are the challenges the Nation faces in making a difference in its health status over the next 5 years.

An interstate network of State year 2000 plans is in place in 41 States and 2 Territories to translate the national objectives to meet State priorities. With 70 percent of local health departments using Healthy People 2000 as a framework to put prevention into action, communities across this country are successfully demonstrating that we can prevent disease and injury and promote health and mental health. Hundreds of national membership organizations, as a part of the HEALTHY PEOPLE 2000 Consortium, are working through their members, be they senior citizens, Girl Scouts, or health care practitioners, to make Healthy People the standard. Federal, State, and local governments, together with private and voluntary organizations, are supporting successful health promotion and disease prevention programs and are building a foundation of health security for all Americans.

Chapter 1 of this report highlights the three goals of Healthy People and provides a summary report of progress on the objectives. Chapter 2 provides an overview of the progress in each of the 22 priority areas. Chapter 3 describes the activities of States in developing their own HEALTHY PEOPLE 2000 objectives and the efforts underway by HEALTHY PEOPLE 2000 Consortium members. Appendix A includes the Summary List of HEALTHY PEOPLE 2000 objectives with 1995 revisions. This includes 19 new objectives and 123 new special population targets to focus the Nation on prevention opportunities and on narrowing, if not eliminating, the gap between certain groups and the total population. The other appendices provide a history of the objectives development and a listing of the contributors to this process.

I want to acknowledge the leadership of Dr. J. Michael McGinnis in applying management-by-objectives to public health. He pioneered the effort by setting in 1979 life-stage targets in *Healthy People, the Surgeon General's Report* that continue to be tracked today. He shepherded the development of the 1990 objectives and ensured the monitoring and public reporting on this first set of national objectives during the 1980s. Through his stewardship, the year 2000 framework was built with the involvement of more than 10,000 individuals from across the Nation. This unprecedented partnership provides us today with a solid foundation for improving health in the next century. I recognize Dr. McGinnis' contribution to prevention as he retires from the U.S. Public Health Service after 21 years of service dedicated to promoting health. He can be assured that the Nation has embraced the concept of using objectives to monitor and report on prevention and that this framework will continue to be vital and vibrant for decades to come.

I commend this report to you. Achieving these goals and objectives and realizing the promise of prevention requires a concerted effort by all Americans in their families, communities, at work, and in school. We can save lives and avert unnecessary illness and suffering by using this blueprint for improving health now and into the 21st century.

Philip R. Lee, M.D.
Assistant Secretary for Health

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CHAPTER 1

The Health of the Nation

**Highlights of the
HEALTHY PEOPLE 2000 GOALS
1995 Report on Progress**

HEALTHY PEOPLE 2000

HEALTHY PEOPLE 2000 provides a vision for achieving improved health for all Americans. Through a national process, people from across the country helped define and are pursuing a prevention agenda for the Nation. Leadership for this process has come from every level of government—national, State, and local—from professional groups, and from people in multiple sectors of American communities working through a HEALTHY PEOPLE 2000 Consortium of more than 300 organizations. Most States have developed HEALTHY PEOPLE 2000 objectives tailored and targeted to their own populations. This midcourse review of HEALTHY PEOPLE 2000 offers an opportunity to renew and reemphasize the importance of prevention and to make midcourse corrections to this decade-long plan for reducing preventable deaths, disabilities, and diseases.

The year 2000 objectives were built upon the 1990 objectives effort, which was initiated in 1979 with the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* and established in 1980 with the publication of *Promoting Health/Preventing Disease: Objectives for the Nation*. Adopting a management-by-objectives planning process familiar in the world of business, the Public Health Service (PHS) set out objectives addressing improvements in health status, risk reduction, public and professional awareness of prevention, health services and protective measures, and surveillance and evaluation, expressed in terms of measurable targets to be accomplished by 1990. These objectives were organized in 15 priority areas under the general headings of preventive services, health protection, and health promotion.

The year 2000 priority areas expanded upon those of the 1990 objectives, with the addition of areas focused on topics such as HIV infection and cancer. In addition, the year 2000 objectives were characterized by an increased emphasis on prevention of disability and morbidity; greater attention to improvements in the health status of definable population groups at highest risk of premature death, disease, and disability; and inclusion of more screening interventions to detect asymptomatic diseases and conditions early enough to prevent early death or chronic illness.

Full achievement of the goals and objectives of HEALTHY PEOPLE 2000 is dependent on a health system reaching all Americans and integrating personal health care and population-based public health. The vision of healthy people in healthy communities moves beyond what happens in physicians' offices, clinics, and hospitals—beyond the traditional medical care system—to the neighborhoods, schools, workplaces, and families in which people live their daily lives. These are the environments in which a large portion of prevention occurs.

This midcourse review reports progress toward the national health promotion and disease prevention objectives. Much has been accomplished; more than two-thirds of the objectives for which data are now available are moving toward the targets. However, in order for the Nation to achieve its prevention agenda and to make a

profound difference in the health of all Americans by the year 2000, renewed efforts will be required. The purpose of this report is to assess the challenges that remain and to demonstrate that the opportunities for achieving a healthier America are at hand.

Prevention As the Foundation for Health

Foundations for achieving and maintaining good health are multidimensional, including mental, emotional, and social elements that are as critical to health outcomes as biomedical ones. A century of biomedical research has improved our ability to predict, diagnose, and intervene against disease. Basic scientific studies have revealed a great deal about the factors that predispose individuals to various health threats and about actions that individuals can take to control risks for disease and disability. Attention has increasingly been focused on health protection and promotion, risk prevention, and equality in the health status of populations.

In 1789 the Reverend Edward Wigglesworth assessed the health of Americans and produced the first American mortality tables. In 1900, the main causes of death in the United States were influenza, pneumonia, tuberculosis, and gastrointestinal infections; the average life expectancy at birth was 47 years. By 1950, there was a phenomenal rise in life expectancy at birth to 68 years, primarily due to improvements in diet, sanitation, the development of antibiotics, and the availability of vaccines. In the 1990s, life expectancy is more than 75 years and the chief causes of death are heart disease and cancer. Chronic diseases have emerged as the leading health problems.

During the 1960s and 1970s epidemiological studies and clinical trials began to characterize the predisposing conditions that lead to chronic diseases. Cigarette smoking, high blood pressure, and high blood cholesterol were determined to be prominent contributors to the occurrence of chronic diseases. Population-based preventive programs were developed to combat these risk factors and the diseases they produced. Many chronic diseases once thought to be the inevitable result of aging were reclassified as avoidable. The realization that disease prevention and health promotion could improve the quality and length of life prompted national interest and resulted in new prevention programs. The Surgeon General initiated a campaign against tobacco use in 1964, and in 1972 the National High Blood Pressure Education Program was established. Private and public organizations were created, often dedicated to a single disease, for research, treatment, eradication of disease, and education of the public about risk factors.

As our knowledge about health and the potential to prevent unnecessary disease and disability has increased, the national perspective on health and disease has changed dramatically. A 1994 assessment by the Centers for Disease Control and Prevention (CDC) estimated that nearly 47 percent of premature deaths among Americans could have been avoided by changes in individual behaviors and another 17 percent by reducing environmental risks. In contrast an estimated 11 percent of premature deaths among Americans are deemed preventable through improvements in access to medical treatment.¹

Of the 2.1 million deaths in the United States in 1992, one-third were attributable to heart disease and one-fourth to cancers. HIV infection became the tenth leading cause of death in this country in 1990, and in 1992 was the eighth leading cause. But when one looks beyond the vital statistics records and examines the causes underlying premature deaths, the real benefits of behavioral changes, risk-reduction strategies, and clinical preventive services become evident.

- The elimination of tobacco use alone, either through the prevention of its initial use or through cessation of its current use, could prevent over 400,000 deaths annually from cancer, heart and lung diseases, and stroke.
- Better dietary and exercise patterns can contribute significantly to reducing conditions like heart disease, stroke, diabetes, and cancer, and could prevent 300,000 deaths.
- The prevention of underage drinking and excess alcohol consumption could prevent nearly 100,000 deaths, particularly in reducing deaths from motor vehicle crashes, falls, drownings, and other alcohol-related injury deaths.
- Most injuries, which account for the largest number of deaths among young Americans, can be prevented through safety measures at worksites, at home, in recreational settings, in communities, and on roadways. Improved worker training and safety programs could reduce occupational injuries and diseases, improve productivity, and lower medical care costs.
- Immunizations could prevent many infectious childhood diseases and prevent serious, sometimes fatal diseases among adults. It is estimated that about 63,000 of 90,000 deaths attributable to microbial agents each year could be prevented through immunizations.
- Violent acts with firearms—murder, suicide, and accidental discharge—have emerged as a leading threat to Americans. Firearms now account for about 35,000 deaths each year. Ensuring that weapons are kept out of the hands of children and adolescents could reduce the tragedies of accidental discharge and suicides. Addressing the use of guns by adolescents and young adults in homicides is an imperative of the public health agenda.
- Unprotected sexual intercourse leads to unintended pregnancies, sexually transmitted diseases (STDs), and HIV infection, accounting together for 30,000 preventable deaths each year. Another tragedy of STDs is the number of children born with congenital syphilis or HIV infection.

- Screening for breast and cervical cancer could save lives and reduce extensive treatment.
- Recognition and control of high blood pressure and elevated blood cholesterol levels can protect against heart attacks and strokes.²

The scope of preventable loss of life, nearly 1 million Americans each year, is not news to the public health community. Public health professionals from around the country have been working—with remarkable success under constrained conditions—to shift the national emphasis to prevention. Since the 1970s, stroke death rates have declined by 58 percent, and coronary heart disease death rates have dropped by 49 percent. Tobacco use among adults declined from 34 percent to 25 percent between 1974 and 1993. Increased use of automobile safety restraints contributed to a 32 percent decline in the death rate from car crashes. The number of people living in counties meeting the clean air quality standards of the U.S. Environmental Protection Agency (EPA) increased by 23 percent between 1988 and 1993.³ At the same time, however, AIDS, tuberculosis, asthma, and birth defects have increased, especially in poor and underserved populations. The need for renewed commitment to meet prevention challenges has never been more compelling.

Despite the fact that knowledge exists to help avoid premature death, serious illness, and chronic disability, they continue to occur—and they are costly. For example, physical injuries, both unintentional (“accidental”) and violent, cost more than \$150 billion annually. The financial burden of heart disease and stroke amounts to about \$135 billion a year. The annual health care and related costs attributable to alcohol abuse are \$98.6 billion and to illicit drug use, \$66.9 billion. The yearly costs of tobacco use amount to about \$65 billion.⁴

This report calls for renewed commitment to improving the Nation’s health. *HEALTHY PEOPLE 2000* cannot be accomplished by the Federal Government alone. Leadership must come from institutions and individuals throughout the Nation. Each person makes decisions about how fast to drive, whether to wear a safety belt, what to eat, and how much alcohol to drink. In families, parents have the opportunity to promote health and encourage healthy habits for their children. Community organizations—schools, religious institutions, and voluntary organizations—can become more actively engaged in promoting health. Employers can make worksites healthy. This midcourse review offers not only a report to the Nation on progress to date, or a blueprint for what is possible by the year 2000, but it outlines opportunities to renew the Nation’s commitment to making a difference in the health of its citizens as the 21st century approaches.

HIGHLIGHTS OF THE HEALTHY PEOPLE 2000 GOALS

Goal 1—Increase the span of healthy life

The first HEALTHY PEOPLE 2000 goal is to increase the span of healthy life for all Americans—here the emphasis is on healthy years, not just longevity. The good news is that people are living longer. Life expectancy at the time that the first *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* was published in 1979 was 73.7 years.⁵ When HEALTHY PEOPLE 2000 was released in 1990 life expectancy was 75 years. On average babies born in 1992 will live an additional three quarters of a year, with life expectancy at nearly 76 years.⁶

Using self-reported health status and activity limitation data in the National Health Interview Survey, coupled with standard life tables produced by the CDC, National Center for Health Statistics (NCHS), 64 years of life (or 85 percent of life years) are estimated to be healthy. Some 11.4 years of life (or 15 percent of life years) are estimated to be unhealthy, with limitations of major life activities such as self-care (bathing, grooming, and cooking), recreation, school, and work. Because activity limitations increase with age, the challenge in this goal is to minimize disability and to increase independence and health of older adults.

Among racial and ethnic minorities the percentage of life years considered healthy varies. The number of years of healthy life for Hispanics (64.8 years) was slightly less than that of whites in 1990. Blacks, however, had substantially fewer years of healthy life (56.0 years).

New 1992 estimates of years of healthy life years show a decline in health-related quality of life despite increases in life expectancy. The Nation appears to be losing ground on this important goal. This measure will be used to track this goal throughout the decade, while research continues on refining the measurement tool for years of healthy life. In the meantime, this measure enables the Nation to move from merely tracking mortality to examining also the quality of life.

Goal 2—Reduce health disparities among Americans

The second goal is to close the gaps in health status and health outcomes between racial and ethnic minorities and the total population. Across many health measures—mortality, morbidity, and health services utilization—the differences between whites and minorities continue to be substantiated.

Figure 1. Years of Healthy Life and Life Expectancy, by Race and Hispanic Origin, 1990

	All Races	White	Black	Hispanic
Healthy Years	64.0	65.0	56.0	64.8*
Life Expectancy	75.4	76.1	69.1	N/A

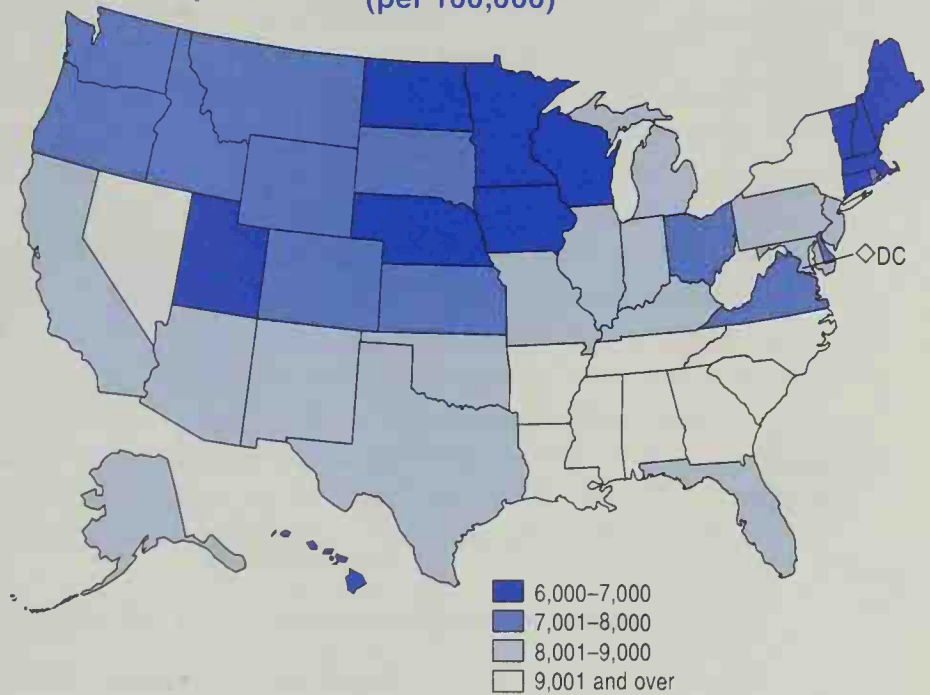
* Estimated from preliminary data.

Source: Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS)

Years of potential life lost (YPLL) is a measure of premature death. Figures 2 through 5 show the years of potential life lost before age 75 (YPLL-75) per 100,000

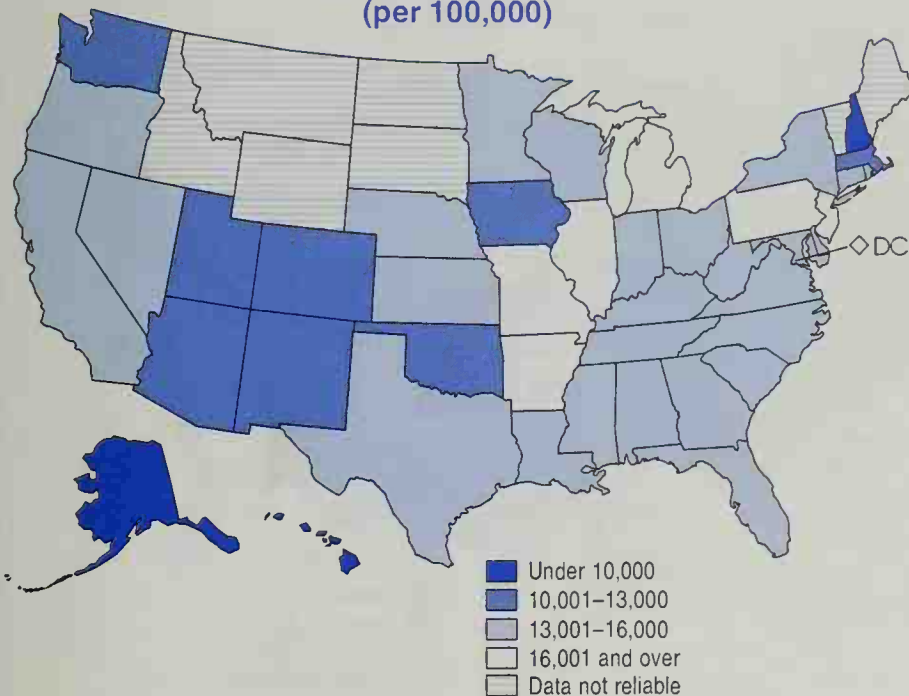
State population for selected racial and ethnic populations for the 3-year period 1990–92. In the calculation of YPLL-75, infants who die before their first birthday have lost 74.5 years of life; a person dying at 50 years has lost 25 years of life. Therefore, the younger the decedent, the more years of potential life lost. To facilitate comparisons among States and racial/ethnic groups with different age compositions, the data have been age-adjusted to the 1940 U.S. standard population. Data are not shown for States for which the number of

Figure 2. Years of Potential Life Lost (YPLL) Among All Races Before Age 75, by State, 1990–1992*
(per 100,000)



* Age-adjusted years of potential life lost before age 75 for all causes of death
Source: CDC/NCHS

Figure 3. Years of Potential Life Lost (YPLL) Among Blacks Before Age 75, by State, 1990–1992*
(per 100,000)

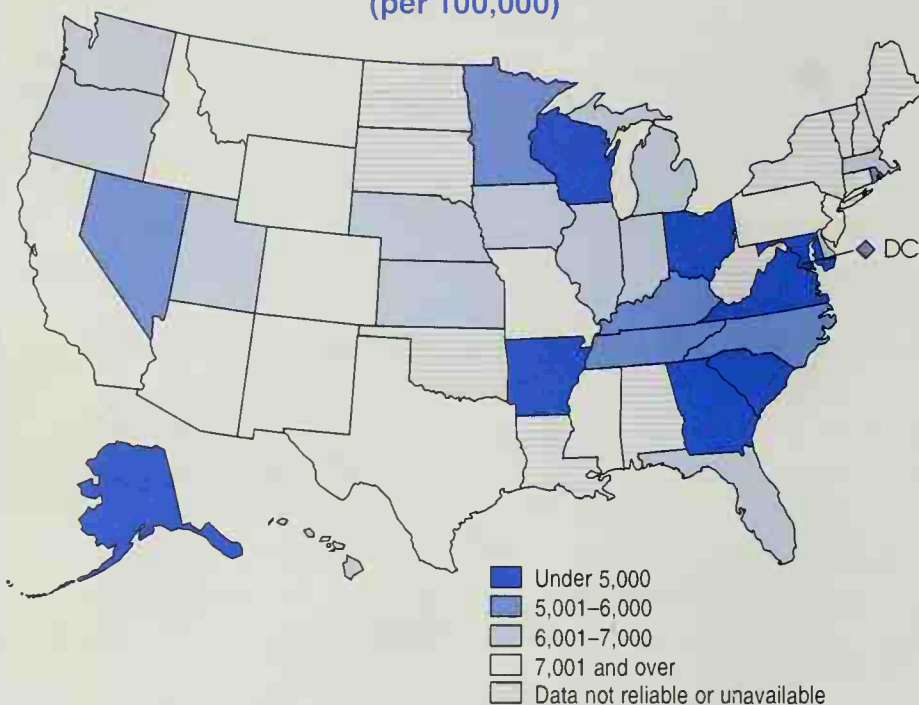


* Age-adjusted years of potential life lost before age 75 for all causes of death
Source: CDC/NCHS

deaths was too small to compute a reliable rate. Figure 4 data are also not shown for the five States (Connecticut, Louisiana, New Hampshire, New York, and Oklahoma) for which Hispanic origin data for 1990–92 were not available from the National Vital Statistics System.

For the United States as a whole, the 1990–92 age-adjusted YPLL-75 for all races was 8,384 per 100,000. For blacks and American Indians/Alaska Natives in

Figure 4. Years of Potential Life Lost (YPLL) Among Hispanics Before Age 75, by State, 1990–1992* (per 100,000)



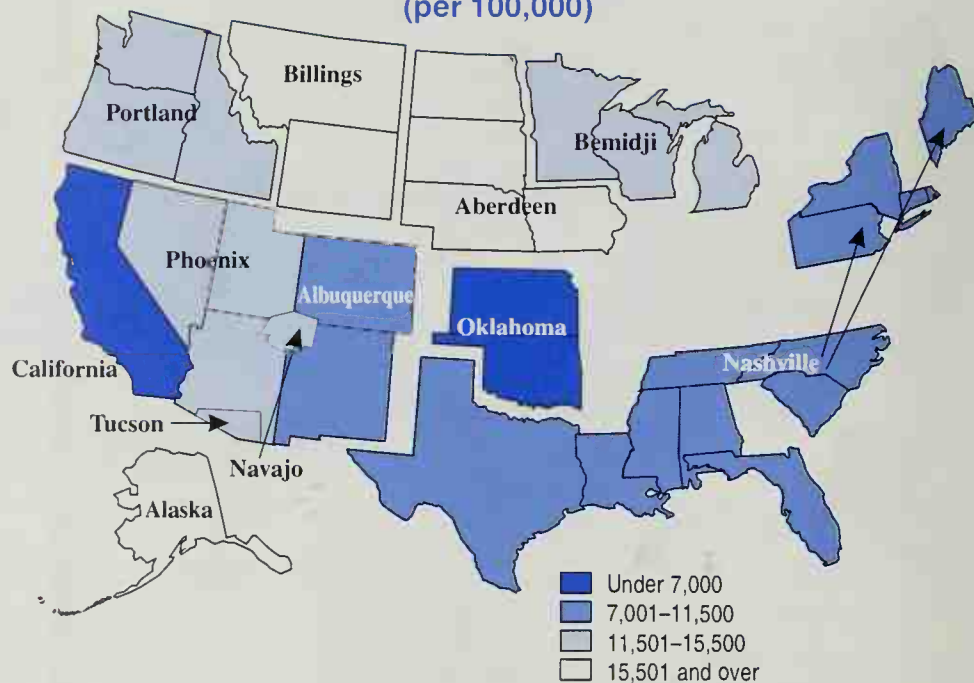
* Age-adjusted years of potential life lost before age 75 for all causes of death
Source: CDC/NCHS, 1990-92 combined

Indian Health Service (IHS) areas the rates are considerably higher, 15,468 and 11,875, respectively. This disparity reflects the higher mortality for blacks for a number of major causes of death that primarily affect younger people such as infant mortality, homicide, and HIV infection. Contributing to the disparity for American Indians/Alaska Natives are higher rates for infant mortality, unintentional injury death, homicide, and suicide. Because there are known problems with the underreporting of

Indian race on death certificates, these YPLL rates are considered to be conservative. For Hispanics, YPLL-75 is 7,114 per 100,000 reflecting lower death rates for most major causes of death.

Assessment of health disparities among Americans requires data systems that collect information on race, ethnicity, socioeconomic status, and disabilities. Such systems are addressed by

Figure 5. Years of Potential Life Lost (YPLL) Among American Indians/Alaska Natives Before Age 75, by Indian Health Service Areas, 1990–92* (per 100,000)



Note: Total IHS=11,874.9

* Age-adjusted to the standard 1940 U.S. population under age 75

Source: IHS

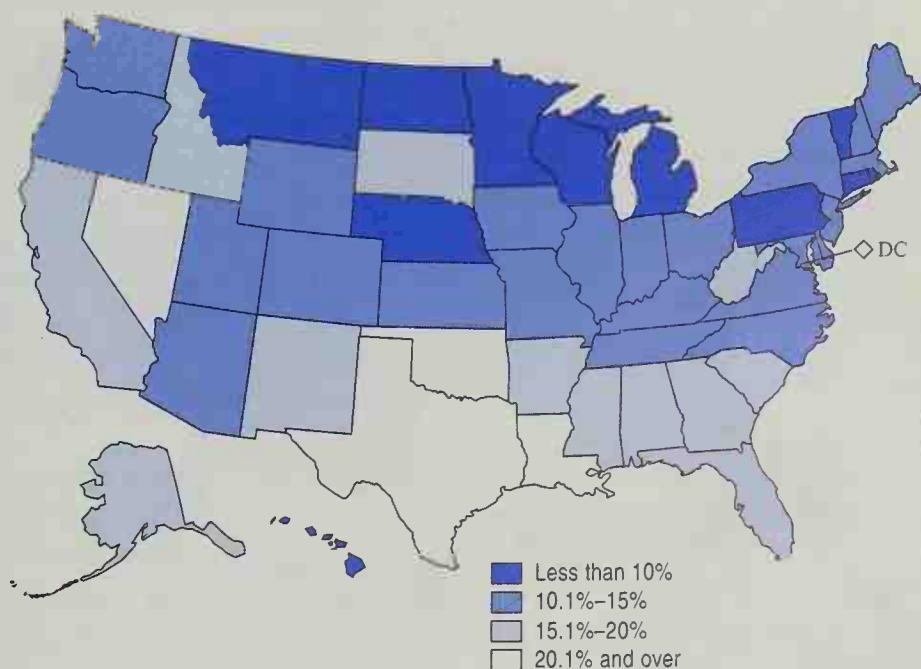
HEALTHY PEOPLE 2000 objective 22.4, which calls for development of a national process to identify gaps in the Nation's disease prevention and health promotion data for racial and ethnic minorities, people with low income, and people with disabilities, and to establish mechanisms to meet these data needs.

A note of caution should be expressed about the ability to identify health disparities. The lack of data about subgroups of the population and small geographic areas hampers the ability to quantify health problems. In recent years, oversampling of blacks and Mexican Americans in national surveys has taken place, providing data that show disparities. These data have been used to establish new HEALTHY PEOPLE 2000 population targets in this 1995 revision. But as the United States becomes more diverse, the challenge of identifying disparities as they emerge and addressing differences in health status and health outcomes will increase. To meet the ambitious year 2000 targets set forth in HEALTHY PEOPLE 2000 will require improvements in the information available on health status, behaviors, and clinical preventive services utilization of population groups at greater risk for health problems including racial and ethnic minorities, as well as people with disabilities and people with low income.

Goal 3—Achieve access to preventive services for all Americans

The third goal is to achieve access to preventive services for all Americans. Setting this goal put the Nation on record in 1990 as being committed to universal access to preventive health services as a part of primary care. As a result of the work of the U.S. Preventive Services Task Force, substantial consensus has emerged about what services should be made available to various groups at regular intervals. On the other hand, the percentage of Americans with health insurance coverage has declined, creating a barrier to delivery of these services. Although 77 percent of people under age 65 had private insurance in 1986, only 71.9 percent had it in 1992. While some of these people were covered by Medicaid, which increased coverage from 6 percent of Americans in 1986 to 9.2 percent in 1992, the

Figure 6. Health Insurance Coverage for People Age 64 and Younger, Percent Uninsured by State, 1992



Source: U.S. Bureau of the Census

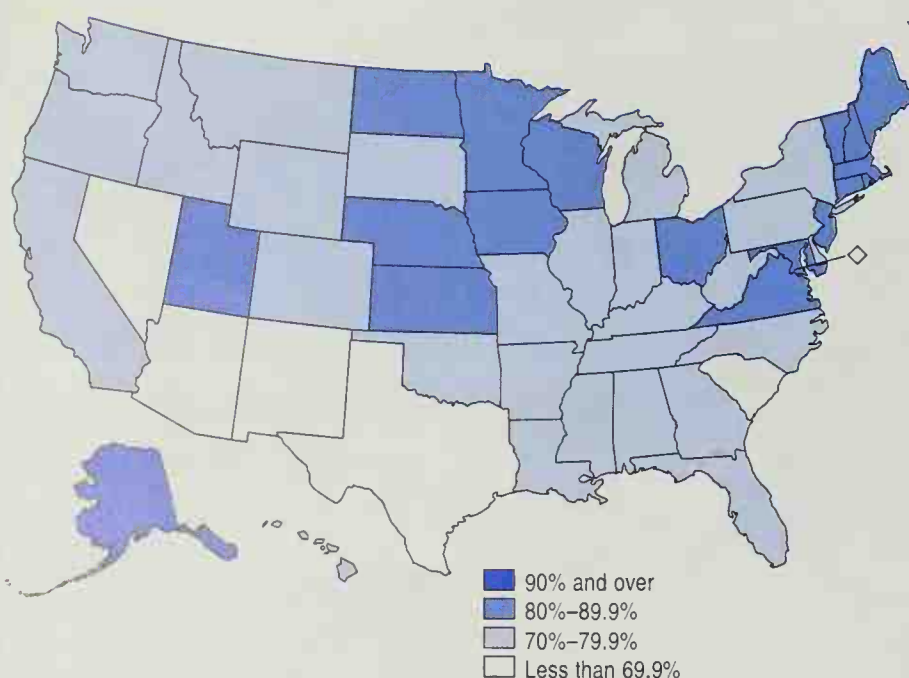
number of people who were uninsured rose from 15 to 17.2 percent over this same period. Among blacks and Hispanics (data on other races are unavailable), the percentage of uninsured is even greater. Using data from the 1993 Current Population Survey, which encompassed all people regardless of age, the Census Bureau estimated that 39.7 million Americans, or 15.3 percent, were without health insurance. Among blacks, 20.5 percent were uninsured, as were 31.6 percent of Hispanics.

First trimester prenatal care is one measure of the extent to which women have access to primary care. Data from the 1991 National Vital Statistics System indicate that no State had achieved the HEALTHY PEOPLE 2000 target of 90 percent of pregnant women receiving first trimester prenatal care. However, 18 States had first trimester prenatal care rates exceeding 80 percent. The New England States, several midwestern States, Maryland, and Virginia were among them. Connecticut, Iowa, Maine, and Rhode Island all had rates of first trimester prenatal care exceeding 85 percent. The receipt of prenatal care also differs by race. In 1991, American Indians/Alaska Natives had the lowest rate of first trimester prenatal care—59.9 percent—compared with 61.9 percent for blacks, 61.0 percent for Hispanics, and 79.5 percent for whites.

Life-Stage Objectives

With the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1979, broad national goals were established for 1990 for mortality rate reductions in four age groups from birth to age 65 years. These life-stage targets continue to be tracked as objectives for the year 2000.

Figure 7. Prenatal Care in the First Trimester, by State of Residence of the Mother, 1992



Source: CDC/NCHS, Vital Health Statistics, Natality Division, 1992

Infant mortality is one of the sentinel events in health and a broad measure of a Nation's health. Although infant mortality declined by 35 percent between 1977 and 1990, the grim fact remains that 33,000 babies still die each year before their first birthday. The United States ranked 22nd among industrialized countries in its infant mortality rate in 1991.⁹ The newest data show continued improvements in the infant mortality rate—as of

Figure 8. Progress on Life-Stage Objectives, 1995

Age Group	Year 1990 Targets*			Year 2000 Targets*		
	1977 Baseline	1990 Target	1990 Final	1987 Baseline	2000 Target	1992 Status
Infants (aged <1)	1412	900	908	1008	700	852
Children (aged 1–14)	42.3	34	30.1	33.7	28	28.8
Young People (aged 15–24)	114.8	93	104.1	97.8	85	95.6
Adults (aged 25–64)	532.9	400	400.4	426.9	340	394.7

* Deaths per 100,000 population
Source: CDC/NCHS National Vital Statistics System

1992, the infant mortality rate was 850 per 100,000 people under the age of 1 year. On the other hand, the rate per 100,000 live births for blacks was more than double the rate for whites. This disparity is one of the most important reasons for the HEALTHY PEOPLE 2000 target. Reducing infant mortality by 30 percent during the 1990s will require special emphasis on reducing the prevalence of low birthweight babies and on preventing birth defects.

For the year 2000, a 15 percent mortality reduction was set as the target for children aged 1–14. This level was nearly reached in 1992 as the child death rate reached 28.8 per 100,000. Significant declines in injury deaths, particularly from motor vehicle crashes, have contributed to this success story. By 1985, child safety seat use had become mandatory in all 50 States and the District of Columbia.

For adolescents and youths aged 15–24, the reduction in mortality has fallen short of the target. In fact, this was the only life-stage goal not met in 1990. For the year 2000, a 15 percent mortality reduction was established as the goal. In 1992, with 95.6 deaths per 100,000 population, this life-stage goal is proving elusive. Real progress is needed in curbing both interpersonal and self-inflicted violence in order to achieve the year 2000 target. Reducing motor vehicle crash deaths, particularly those involving alcohol, is another challenge for this age group.

A 20 percent reduction in the adult aged 25–64 death rate is the goal for the year 2000. Real progress has occurred in reducing heart disease and stroke death rates for adults. Successful efforts to increase high blood pressure detection and control, to raise awareness of blood cholesterol and dietary fats, and to warn of the hazards of tobacco use have contributed to the progress in this area. Cancer now is the leading

cause of death for this age group. Slowing the rise in cancer deaths and in HIV infection remains a real obstacle to the achievement of the year 2000 target for adults.

The 1990 goal of reducing the days of disability for persons over 65 years of age was not met, although considerable progress was made. On an age-adjusted basis, restricted activity days declined on average from 36.5 days in 1977 to 31.4 days in 1990, compared with the goal of 30 days. For the year 2000, the life-stage goal set for older adults is to reduce the proportion of people who have difficulty in performing two or more personal care activities, thereby preserving independence. Personal care activities include bathing, dressing, grooming, and eating. According to data from the National Health Interview Survey, about 33 percent of people aged 65 and over were limited in one or more personal care activities.

1995 REPORT ON PROGRESS

At the midpoint of the decade, the Nation and the public health community are examining the health status of all Americans. While all of the data are not in hand, many 5-year trends have been established. Overall progress has been made on the Nation's year 2000 targets, with 50 percent proceeding in the right direction, 18 percent moving away from the targets, and 3 percent showing no change from the baseline. Tracking data are not yet available for 29 percent. The priority area midcourse reviews of the 22 HEALTHY PEOPLE 2000 priority areas that follow in the next chapter provide a more detailed picture of the changes.

For racial and ethnic population groups there is a similar picture of progress, with roughly the same percentage of objectives moving in the right direction for minorities as for the total population. However, for blacks there are proportionately more objectives moving away from the targets. For Asian Americans there is a considerable problem in getting the data needed to track progress.

Figure 9. Progress on Racial and Ethnic Minority Objectives, 1995

	Right Direction	Wrong Direction	No Change	No Tracking Data*
Total Population (300 targets)	50%	18%	3%	29%
Special Populations (116)	53%	27%	3%	17%
Black (48)	50%	35%	2%	13%
Hispanic (28)	54%	14%	4%	29%
Asians/Pacific Islanders (9)	56%	11%	0%	33%
American Indians/Alaska Natives (31)	56%	31%	3%	10%

* Includes objectives with no baseline (8%) and objectives with no update beyond baseline (22%)
Source: CDC/NCHS

Another summary of progress is shown in Figure 10 on the status of the 47 sentinel objectives in the 22 HEALTHY PEOPLE 2000 priority areas. The picture is also one of progress—33 objectives are proceeding in the right direction, 9 are moving away from the targets, 2 show no change from the baseline, and 3 lack data to track progress.

Prevention Opportunities

Families, schools, worksites, and community programs all provide important opportunities for prevention. Midcourse assessments of HEALTHY PEOPLE 2000 objectives point to the continuing need to deal effectively with problems experienced by families and even whole communities—problems such as poverty, insufficient education, single parenthood, and violence, that can only be addressed through those settings.

Families

Beginning a family should be one of the joys of life. Through family planning, parents can ensure that they are ready to assume responsibility to care for and provide for their children. Once the choice has been made to begin a new life, the mother has the responsibility of seeking prenatal care in the first trimester of pregnancy to ensure a healthy birth. Breastfeeding can also help give a child a healthy start. A nutritious diet that supports physical growth and development coupled with physical activity can ensure that a child begins life with healthy habits. It is within families that behaviors are first observed and learned. Diet and activity patterns, oral hygiene, and coping skills are established at an early age and are supported by the examples set by family members. Patterns of alcohol consumption and tobacco use are similarly established within families. For adolescents and young adults, learning about physical development can foster positive awareness of their sexuality. Promoting self-esteem and reinforcing positive behaviors also builds the mental health of children. Primary care providers can support families by ensuring that they are provided scientifically sound clinical preventive services, including immunizations, screening to detect asymptomatic disease in its early stages, and appropriate counseling to foster healthy behaviors.

Schools

For the nearly 48 million children in this country, schools play an important supporting role in maintaining and promoting good health. Schools can provide health education to prepare children and teenagers to care for themselves. Children can learn about their bodies and the health effects of different behaviors and can adopt patterns for healthy life for themselves. In and through schools, children can be linked to necessary preventive services, including nutritious meals, regular physical activity, age-appropriate immunizations, screening for early diagnosis of diseases, referrals for treatment, and appropriate counseling about the many challenges to healthy maturation. Recognizing the role of schools in ensuring health for young citizens, the need for enhancing school health education and for developing school-based and school-linked health services is clearly called for.

Figure 10. Progress on 47 Sentinel Objectives

Objective	% Change Targeted	Baseline ^a	Update ^g	Year 2000 Targets	Right Direction	Wrong Direction	No Change	No Data
HEALTH PROMOTION								
1. Physical activity								
• more people exercising regularly	+36%	22% ^c	24% ⁱ	30%	X			
• fewer people never exercising	-38%	24% ^c	24% ⁱ	15%			X	
2. Nutrition								
• fewer people overweight	-23%	26% ^b	34% ^h	20%		X		
• lower fat diets	-17%	36% ^b	34% ^h	30%	X			
3. Tobacco								
• fewer people smoking cigarettes	-48%	29%	25%	15%	X			
• fewer youth beginning to smoke	-50%	30%	27%	15%	X			
4. Alcohol and other drugs								
• fewer alcohol-related automobile deaths (per 100,000)	-13%	9.8	6.8	8.5	X			
• less alcohol use among youth aged 12–17 years	-50%	25.2% ^e	18.0%	12.6%	X			
• less marijuana use among youth aged 12–17 years	-50%	6.4% ^e	4.9%	3.2%	X			
5. Family planning								
• fewer teen pregnancies (per 1,000)	-30%	71.1% ^{c, r}	74.3% ^r	50.0 ^r		X		
• fewer unintended pregnancies	-46%	56% ^e	NA	30%				X
6. Mental health and mental disorders								
• fewer suicides (per 100,000)	-10%	11.7	11.2	10.5	X			
• fewer people reporting stress-related problems	-21%	44.2% ^c	39.2%	35%	X			
7. Violent and abusive behavior								
• fewer homicides (per 100,000)	-15%	8.5	10.3 ^k	7.2		X		
• fewer assault injuries (per 100,000)	-10%	9.7 ^d	9.9 ^k	8.7		X		
8. Educational and community-based programs								
• more schools with comprehensive school health education	NA	NA	NA	75%				X
• more workplaces with health promotion programs	+31%	65% ^c	81% ^k	85%	X			

Figure 10. Progress on 47 Sentinel Objectives (continued)

Objective	% Change Targeted	Baseline ^a	Update ^g	Year 2000 Targets	Right Direction	Wrong Direction	No Change	No Data
17. Diabetes and chronic disabling conditions								
• fewer people disabled by chronic conditions	-15%	9.4%	10.6%	8%		X		
• fewer diabetes-related deaths (per 100,000)	-11%	38 ^d	38 ^k	34			X	
18. HIV infection								
• slower increase in HIV infection (per 100,000)	0%	400 ⁱ	NA	400				X
19. Sexually transmitted diseases								
• fewer gonorrhea infections (per 100,000)	-25%	300 ⁱ	172	225	X			
• fewer syphilis infections (per 100,000)	-45%	18.1 ⁱ	10.4	10.0	X			
20. Immunization and infectious diseases								
• no measles cases	-100%	3058 ^{e,q}	312 ^q	0	X			
• fewer pneumonia and influenza deaths (per 100,000)	-63%	19.9 ^o	23.1 ^p	7.3		X		
• higher immunization levels (ages 19–35 months)	+53%	54–64%	67%	90%	X			
21. Clinical preventive services								
• no financial barrier to recommended preventive services	-100%	16% ⁱ	17%	0		X		
SURVEILLANCE AND DATA SYSTEMS								
22. Surveillance and data systems								
• common and comparable health status indicators in use across States		0 States	48 States	40 States	X			
Total						33	9	2 3

^a 1987 unless otherwise noted
^b 1976–80
^c 1985
^d 1986
^e 1988
^f 1989
^g 1993 unless otherwise noted
^h 1988–91
ⁱ 1990
^j 1991
^k 1992
^l 1994
^m 1983–1987
ⁿ 1984
^o 1979–80 through 1986–87
^p 1987–88 through 1989–90
^q Data are expressed as measles cases rate per 1,000 influenza seasons

Low educational achievement is a consistent indicator of increased risk for preventable disease and premature death. With the passage of the GOALS 2000 Educate America Act, the potential exists to initiate a broad range of actions that, together with HEALTHY PEOPLE 2000, will result in a healthier, better educated Nation. GOALS 2000 challenges the Nation to ensure that all children arrive at school ready to learn; to increase the high school completion rate; to attain student competencies in core subjects; to make U.S. students first in the world in math and science achievement; to improve teacher education and professional development; to achieve universal adult literacy and lifelong learning; to ensure safe, disciplined, and alcohol- and drug-free schools; and to promote parental participation. Achieving these goals can produce a generation of educated adults for whom disease prevention and health promotion is understood, practiced, and valued.

Workplaces

Nearly 110 million people go to work each day. A prevention-based orientation to health can be enhanced by employers who promote good health for their employees through supportive policies (e.g., smoking restrictions), exercise facilities, health promotion education, health insurance, and targeted preventive services. In addition, workplace programs protect employee health through standard setting and enforcement, worker training, and safety education. By encouraging safe practices and healthy behaviors, worksite programs help sustain the national effort to reduce preventable death, disease, and disability.

Communities

Each day, millions of Americans come together to pursue neighborhood improvement projects, engage in recreation, continue their education, and maintain social support and friendship. From athletics to volunteer social service, community-based activities support better health—for participants and recipients alike. For families and neighborhoods that are least able to provide healthy, safe environments, community programs can be a bridge to a better life.

Religious institutions offer spiritual support that can promote emotional and mental health. The religious community has become increasingly engaged in the lives of its members through sponsorship of child care centers, afterschool programs, homeless programs, and programs for older adults. Through all of these activities, churches, temples, and other places of worship promote health.

An increasing number of community-based projects that join the skills, devotion, and energy of the community with the expertise of local public health departments and health care providers promotes better health in America's communities and neighborhoods. These healthy communities projects work to build communities that support good health decisions and promote improvements in the quality of life.

HEALTHY PEOPLE 2000 provides a framework for State and local action, helping communities tailor strategies to meet the unique needs of their residents. As of June 1995, 42 States, Guam, and the District of Columbia had used HEALTHY PEOPLE 2000 to

create their own State-level prevention agendas. Equally impressive is the degree to which private and voluntary organizations have taken on the HEALTHY PEOPLE 2000 challenge. Acceptance of a common prevention agenda has built bridges between public and private agencies at national, State, and local levels. To emphasize the importance of action at the State level, this report is arranged with maps illustrating how statistics from various jurisdictions compare on certain indicators of health.

Prevention Challenges—Special Population Priorities

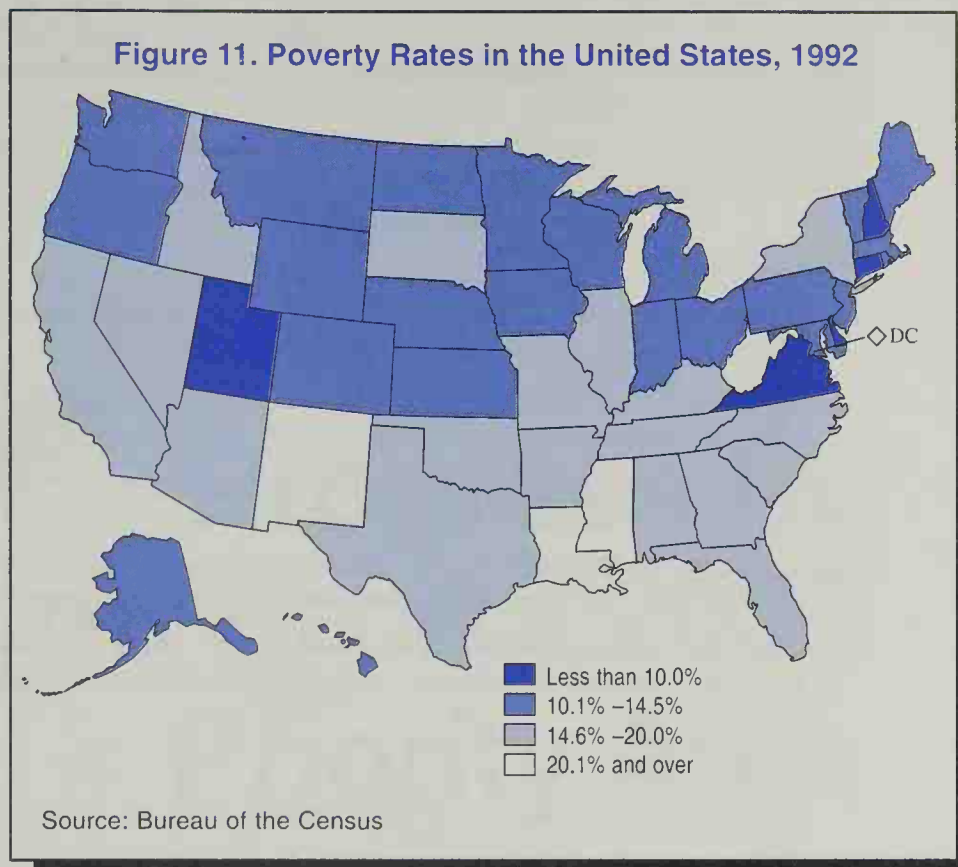
Some problems are so compelling that particular attention is required to change the behaviors of individuals and community norms. These problems occur disproportionately among the most vulnerable in the society, and solutions to these problems require the mobilization of multiple social institutions.

The population of the United States continues to grow and to diversify. At the time of the 1990 census, there were nearly 250 million Americans, with a combined minority population at 24 percent. In 1990, the racial composition of the population was 75.7 percent white non-Hispanic, 11.8 percent black non-Hispanic, 2.4 percent Asians/Pacific Islanders, and 0.7 percent American Indians/Alaska Natives. Based on official Census Bureau projections, the resident population will be 276 million by the year 2000, with a combined minority population of 28.4 percent. This growth of 17.5 million minorities reflects both migration and the natural increase of the population as births exceed deaths. Some 9 percent of the population were of Hispanic origin. By 2000 the population is expected to be 71.6 percent white non-Hispanic, 12.2 percent black non-Hispanic, 4.1 percent Asians/Pacific Islanders and 0.7 percent American Indians/Alaska Natives. Some 11.3 percent of the population are expected to be people of Hispanic origin.¹⁰ As America's diversity increases, so does the need to ensure that broad public health messages are culturally and linguistically appropriate.

By the year 2000, there will also be 4 million more Americans over the age of 65 than there were in 1990. The average age of the population is rising, and the number of people living beyond age 85 is at record levels. The aging of America will challenge the mental health system to minimize the effects of social isolation and depression that arise from illness and from the losses of loved ones and friends. Primary care providers will be faced with identifying risks to independence and health, counseling patients to remain physically active, providing immunizations for pneumonia and influenza, and performing periodic screenings to detect cancers, heart disease, and other life-threatening conditions.

Another special population focus in *Healthy People 2000* is people with disabilities. According to the Census Bureau there were 48.9 million Americans with a disability in 1992. Almost half of these people were considered to be severely disabled, while the disability for the others was considered not severe. Among the severely disabled are the frail elderly, mentally retarded/developmentally disabled people, and adults and children with disabling physical and mental illnesses. These people may be limited in their activities of daily living such as going to work or school or in per-

forming personal grooming, cooking or housework. Although there are no official projections of the disabled population for the year 2000, the trend data indicate that the numbers of disabled may be increasing. In part this trend reflects the aging of the population. The 1994/95 Disability Supplement to the National Health Interview Survey will provide important information on the severity, onset, and duration of disabling conditions.



For nearly every measure of health, the poor suffer more than the population as a whole. The number of people living in poverty has increased since *Healthy People 2000* was published. Between 1987 and 1992, there was an increase of 4.7 million people in poverty—which brought the total population living with incomes below the official poverty level to 36.9 million Americans. Of these, 13.9 million were children under the age of 18. There are no official projections for poverty by the year 2000. As shown in Figure 11, poverty rates differ by State, with Mississippi having nearly three times the rate of poverty of Delaware in 1992.

These demographic trends indicate enormous challenges. To prevent premature death and disability and to thwart morbidity in a more diverse and older population in which poverty has been on the rise requires that health promotion and disease prevention messages and interventions be broadened. Resource constraints require that services be targeted to those with the greatest needs.

Conclusion

Healthy People 2000 offers goals for what can be achieved for the Nation's health by the end of this decade as well as an agenda to realize that vision. Each of the 22 priority areas is important and has substantial impact on the ability to reach the targets comprising other priority areas. Achieving the heart disease and cancer objectives also requires progress in the diet, physical activity, and tobacco use objectives. Reaching targets related to violence and unintentional injury also requires progress on the substance abuse, mental health, and educational and community-based program objectives.

This decade will witness profound changes in the Nation's public and personal health care system. This midcourse review reaffirms a commitment to better health in its broadest sense. *Healthy People 2000* offers an important tool. Its use can ensure that efforts are focused on activities that can reduce the burden of illness and move the Nation steadily toward a higher level of health as a new century dawns.

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CHAPTER 2

Progress by HEALTHY PEOPLE 2000 Priority Area

Review of Progress

1995 Revisions

INTRODUCTION

This chapter examines the progress that has been made to date toward the year 2000 targets in each of the 22 HEALTHY PEOPLE 2000 priority areas. These assessments have been prepared by the lead agencies of the U.S. Public Health Service to provide a snapshot of progress at the midpoint of the decade. In each priority area, a graph illustrates the objectives that are moving toward and away from their targets by measuring the percentage of targets achieved. This explanatory note clarifies how these progress quotients were calculated and why this methodology was employed.

The equation used in measuring progress for each objective is as follows:

$$\frac{(\text{Current Status} - \text{Baseline})}{(\text{Year 2000 Target} - \text{Baseline})} \times 100 = \text{Percentage of Target Achieved}$$

What is being measured is the percentage of the target achieved based on the most current data. This is not simply a statement of the percent change from the baseline. This equation is used so that comparisons can be made between objectives as to the extent of progress made to date on each of the targets. HEALTHY PEOPLE 2000 objectives are measured by differential rates of change. For example some objectives call for a 10 percent change over the decade; others call for a 15 percent change from the baseline; while other objectives, for example, the percentage of people in radon-tested houses, call for a 700 percent increase. Therefore, in order to compare progress among objectives, it is important to look at progress in the context of the total change sought. Complete achievement of a targeted objective would equal 100 percent.

For example, using a 5 percent change from the baseline, the percentage of target achieved would differ depending on the total percent change sought over the decade. If a 10 percent improvement was thought to be realistic and 5 percent has been achieved to date, then the progress quotient is 50 percent. An objective with a 5 percent change and a 700 percent increase between the baseline and 2000 target would have accomplished less than 1 percent of its targeted change.

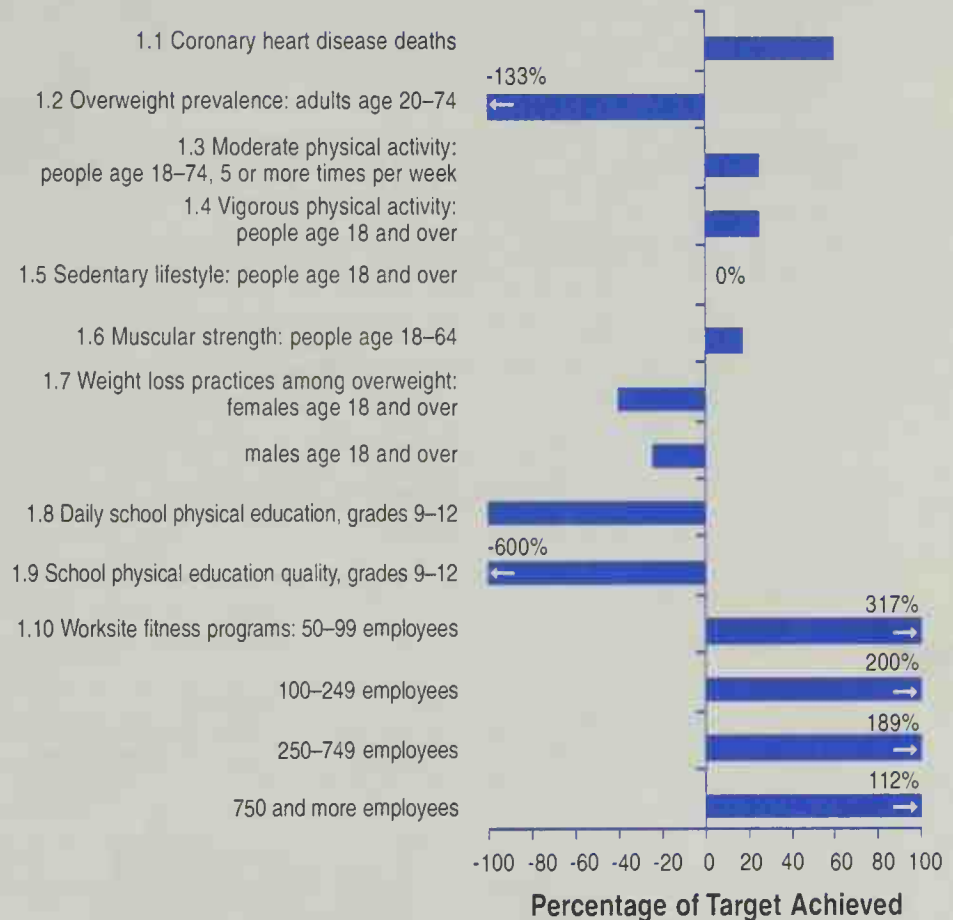
If an update from the baseline is unavailable or no baseline has yet been established for a particular objective, that objective number appears under the listing of "no tracking data available." Unless otherwise noted, the original baseline and target are used in the equation.

The data to support these graphs can be found in *Healthy People 2000 Review, 1994*, a publication of the Centers for Disease Control and Prevention, National Center for Health Statistics. An order form for the *Healthy People 2000 Review* has been provided at the end this document. In addition to the graphs, one objective in each priority area has been chosen for illustration with a map. The purpose of these illustrations is to show which States have already achieved the year 2000 targets and to display comparative status of the States on a selected HEALTHY PEOPLE 2000 objective. The priority area reviews also include a section on the 1995 revisions describing the changes appearing in Appendix A, Summary List of Objectives.

1

Physical Activity and Fitness

Status of Physical Activity and Fitness Objectives



Tracking data for objectives 1.11 and 1.12 are unavailable.

Lead Agency: *President's Council on Physical Fitness and Sports*

PHYSICAL ACTIVITY AND FITNESS

As many as 250,000 deaths per year in the United States have been attributed to a lack of regular physical activity. Good epidemiologic evidence demonstrates that physical activity reduces the risk of many diseases, including heart disease, hypertension, cancer, osteoporosis, and diabetes mellitus. Physiologic evidence shows that physical activity improves many biological measures associated with health and psychological functioning. Regular physical activity and musculoskeletal fitness are important in the maintenance of healthy independent living as people grow older. Clearly, one of the most important public health challenges is moving our society from a sedentary one to a more physically active one.

Although evidence has been accumulating demonstrating the benefits of physical activity, several trends indicate a more sedentary lifestyle. In the "information age," more and more individuals sit in front of computer screens during part or all of their work days. Schools and colleges, hard pressed for financial resources, devote fewer resources to physical activity instruction, playgrounds, or afterschool sports programs. Likewise, communities strapped for resources often have less to invest in parks and recreation facilities or in the staff required to maintain and operate them. Some people are afraid to exercise in their neighborhoods because they fear crime. And children and youth find watching television or playing video games easier than individual or group physical activity.

Public health, medical, and mental health professionals increasingly recognize the importance of physical activity and fitness. Recent consensus conferences have recommended improving adult and adolescent physical activity and have addressed the roles played by health professionals, public health agencies, schools, employers, community planners, and individuals and their families. These conferences noted unique issues in promoting physical activity among economically disadvantaged populations. These recommendations, coupled with attention to each of the objectives tracked in this midcourse review, should help us move toward a more healthy and vibrant Nation.

Review of Progress

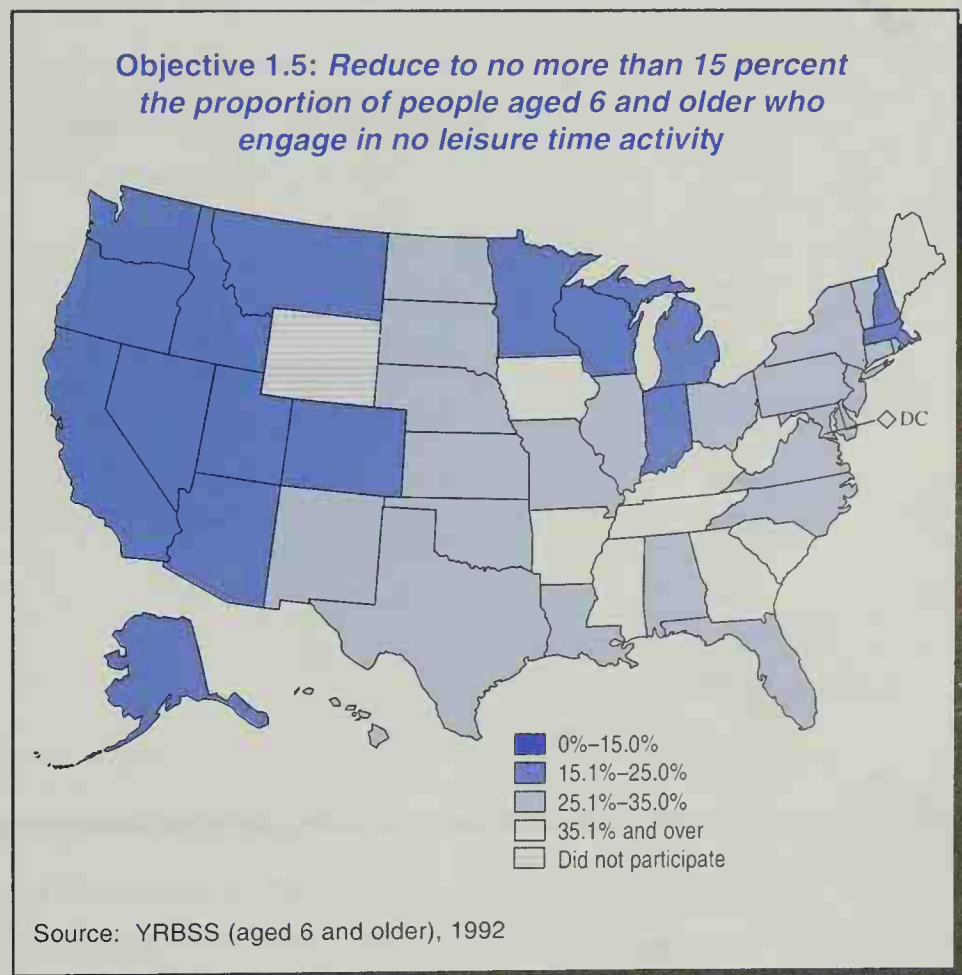
Among the objectives proceeding toward the year 2000 target is the coronary heart disease death rate, which has been declining steadily. Both objectives for increased moderate and vigorous physical activity among adults are showing progress. However, there has been no reduction in the percentage of adults who engage in no leisure-time physical activity. There is some improvement in the percentage of adults improving muscular strength as measured by weight-lifting. For a number of the physical activity objectives, there are no data available on children. The 1993 Youth Risk Behavior Surveillance System (YRBSS) data show that students in grades 9–12 are engaged in stretching (55 percent) and strengthening (52 percent) activities four or more times per week.

Two objectives moving in the wrong direction are the percentage of students engaged in daily school physical education and the proportion of school physical education time that students spend being physically active. These objectives are being measured for students in grades 9–12 because data have not been collected on children in elementary and junior high grades.

One in five teenagers and one in three adults are overweight. The data from 1988–91 indicate that in the United States obesity has increased among children, adolescents, and adults. Overweight is a particular concern for special population groups, including low-income and certain racial and ethnic populations. Despite improvements in the American diet, overweight prevalence has increased. Another objective moving away from the year 2000 target is the percentage of overweight adults who are engaging in weight-loss practices. For both males and females, the proportion adopting sound dietary practices combined with regular physical activity to attain an appropriate body weight has declined.

Worksite fitness programs have the potential to encourage employees to be physically active by providing information, incentives, and access to programs, equipment, and facilities. Worksites with 50 or more employees were surveyed in both 1985 and 1992 to assess the extent to which they offer activities to promote fitness. For two groups of employers (50–99 employees and 100–249 employees) the percentage with programs more than doubled. In larger employee groups, there were also impressive gains.

The 1992 Primary Care Providers Survey gives information on the extent to which providers inquire about exercise habits and formulate an exercise plan. Internists reported routinely inquiring about exercise habits of 40 percent of their patients and formulating an exercise plan for 25 percent; nurse practitioners reported routinely inquiring about exercise habits of 30 percent of their patients and formulating an exercise plan for 14 percent. Even lower levels were



evident among other groups of providers: among pediatricians, 16 percent for both; among obstetricians/gynecologists, 14 and 13 percent respectively; and among family practitioners, 19 and 18 percent, respectively.

No data are available to update the objective calling for an increase in community recreation facilities.

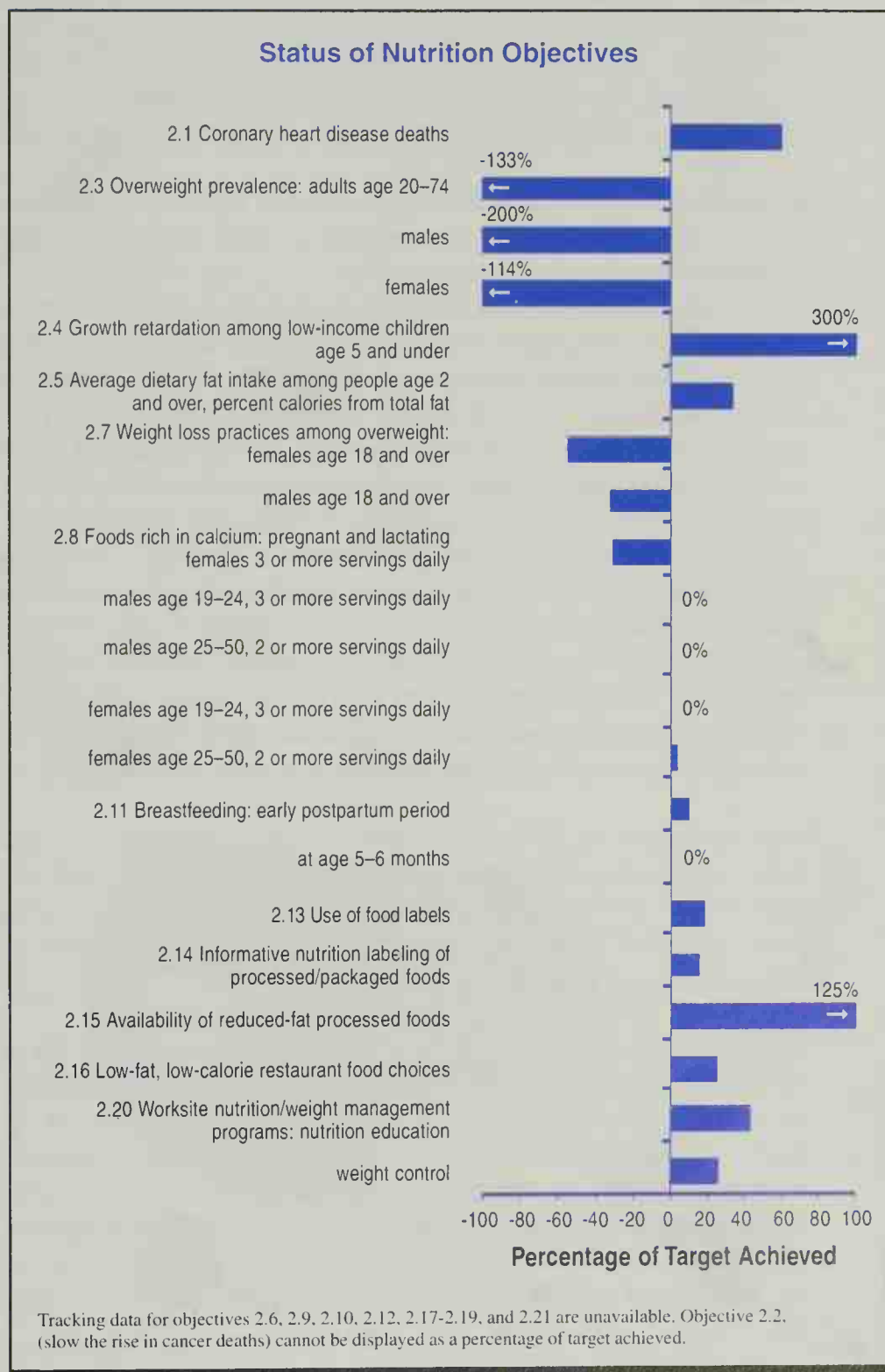
1995 Revisions

Objective 17.3 from the Diabetes and Chronic Disabling Conditions priority area, on performance of activities of daily living, has been added as a shared objective in the Physical Activity and Fitness priority area. This addition occurs because physical activity can help older adults maintain their ability to perform activities of daily living and can preserve independence.

Other revisions include the addition of special population targets for objectives to reduce overweight prevalence among Mexican-American men, to increase the adoption of weight-loss practices by overweight Hispanic males and females, to increase moderate physical activity for Hispanic adults, to increase vigorous physical activity for black and Hispanic adults, and to reduce the proportion of blacks, Hispanics, and American Indians/Alaska Natives who engage in no leisure-time physical activity.

2

Nutrition



Lead Agencies: *National Institutes of Health*
Food and Drug Administration

NUTRITION

One in three adults (34 percent)¹ and one in five adolescents (21 percent)² in the United States are overweight. The data from 1988–91 indicate that the prevalence of overweight has increased over the last decade for adults and adolescents. Overweight is especially prevalent among certain racial and ethnic groups; for example, nearly half of black women and Mexican-American women are estimated to be overweight. To reverse these overweight trends, actions are needed in both the nutrition and physical activity arenas to help people reduce their fat consumption, increase their fruit and vegetable intake, and pursue more physical activity.

Because dietary practices that are learned at a young age may be carried into adulthood, establishing healthy dietary patterns at an early age is important. The Nation's schools and child care centers play an important role in complementing and reinforcing efforts at home to educate children about nutrition principles in the *Dietary Guidelines for Americans*,³ to provide meals consistent with these principles, and to offer opportunities for daily physical activity. Key elements of the Nation's primary prevention strategy against obesity and chronic diseases are provision of proper nutrition that ensures appropriate growth and development of children and adolescents and the maintenance of a healthy diet and healthy weight throughout a person's lifetime.

In addition to the *Dietary Guidelines*, the U.S. Department of Agriculture (USDA) and the Department of Health and Human Services' *Food Guide Pyramid*⁴ is an educational tool for informing children and adults about healthy dietary patterns and the number of recommended servings per day from each food group. Introduced in 1992, the *Food Guide Pyramid* emphasizes the importance of consuming many servings of grains, vegetables, and fruits and of choosing few high-fat foods.

New food labeling helps people make healthy food choices. Under the Nutrition Labeling and Education Act, information about fat and other nutrient content must be provided on a "Nutrition Facts" panel for most processed packaged foods sold in supermarkets.⁵ Now the challenge is ensuring that consumers understand and use this information to make food selections.

Standardized serving sizes for food products can also help the consumer. These sizes reflect the amounts customarily consumed. Uniform definitions are provided for nutrient content claims on food labels such as "low in fat" or "good source of dietary fiber," and certain health claims are authorized on food labels that describe the relationship between a nutrient or food and a disease (e.g., calcium and osteoporosis, fat and cancer, sodium and hypertension). The nutrition labeling requirement for most foods and the desirability of marketing foods with claims about nutrient content has influenced manufacturers to increase the availability of food products with less fat.

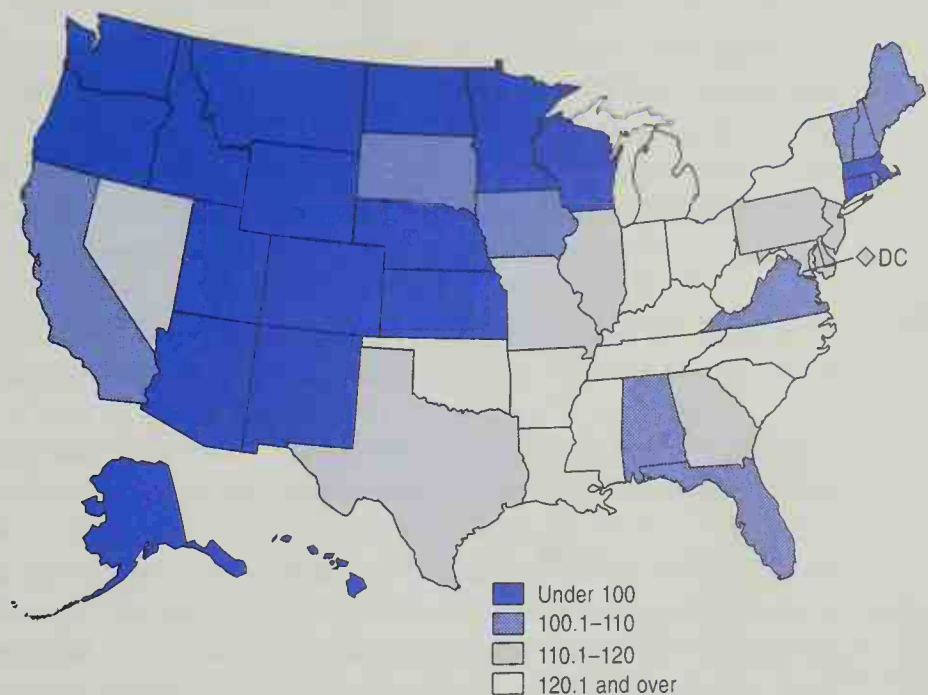
The new food label, the *Dietary Guidelines*, and the *Food Guide Pyramid* provide tools to help people select healthy diets today. Tools for the future will come from basic and applied research seeking to advance the understanding of the role of nutrition in health. Dietary factors that may mitigate the risk of developing a disease or the effects of a disease condition continue to be clarified and discovered, as are biochemical defects and their markers for such health conditions as obesity. Research also continues into gender, age, and cultural differences in food and nutrient intakes and in educational approaches that are effective with different population groups. In addition, research will further the base of knowledge about the role that diet plays in health compared to other lifestyle factors such as physical activity and the role of genetics.

Review of Progress

Breastfeeding is important for giving infants a good nutritional start in life. The proportion of women who breastfeed their babies has shown some positive change for the early postpartum period over a 5-year period, according to the Ross Laboratories Mothers Survey. In 1988, 54 percent of women breastfed their babies; that percentage increased to 56 percent in 1993. The proportion who continue breastfeeding until their babies are 5 to 6 months old was 21 percent in both 1988 and 1992. Among special population groups, there has been considerable progress in the percentage breastfeeding during the early postpartum period, thereby narrowing the gap between special populations and the total population. Between 1988 and 1993, the number of low-income women breastfeeding increased from 32 to 38 percent; black mothers, from 25 to 31 percent; Hispanics, from 51 to 56 percent; and American Indian/Alaska Native mothers, from 47 to 51 percent.

The recommendations in the *Dietary Guidelines* aimed at limiting fat consumption, increasing consumption of grains, vegetables, fruits, and calcium-rich foods, and maintaining a healthy weight are directed at the general population aged 2 and older. Results from the most current (1988–91) national food consumption surveys show some improvement from prior years' data for fat—the

Objective 2.1: Reduce coronary heart disease deaths to no more than 100 per 100,000 people.



diets of people aged 2 and older are composed, on the average, of about 34 percent of calories from total fat and 12 percent of calories from saturated fat.⁶ However, only about one-fifth (21–22 percent) of the population has achieved the average daily goal of no more than 30 percent calories from fat, and a similar proportion (21 percent) have met the goal of less than 10 percent calories from saturated fat.

Based on a 1989–91 estimate of intake of fruits and vegetables, the average intake for people aged 2 and older was four servings per day. However, additional analyses of these data indicate that less than one-third of the population consumed the average daily goal of five or more servings per day. Of special note, a majority of people consumed less than one serving of fruit per day.

The Produce for Better Health Foundation, with support from the National Cancer Institute, has undertaken a nationwide campaign to encourage and assist Americans in eating five or more servings of fruits and vegetables a day as a part of a low-fat, high-fiber diet. Known as the 5-A-Day program, this partnership involves grocers, produce suppliers, and Federal and State health agencies. The program has developed a curriculum on nutrition for children aged 5–10 and reached into other community settings such as churches and the workplace. A survey of Americans, undertaken as a part of the project, indicated that only about one-quarter of the population is aware of this dietary recommendation.¹ People who are aware that they should eat at least five servings a day consumed more fruits and vegetables than those who thought two or fewer servings are adequate. Thus, awareness is a good predictor of consumption.

Based on 1989–91 estimates of intake of grain products, the average daily intake for people aged 2 and older was 5.8 servings. Forty percent of people met the average daily goal of six or more servings per day.

Since the mid-1980s, the available data suggest little change in intake of calcium-rich foods. In 1989–91, about half of children aged 2–10 met the average daily goal of two or more servings of milk and milk products. Only about one-fifth of pregnant and lactating women and people aged 11–24 met the average daily goal of three or more servings of milk and milk products. The same proportion of people aged 25 and older met the average daily goal of two or more servings.

Data from the USDA Continuing Survey of Food Intakes by Individuals (CSFII) show that 43 percent of main meal preparers did not use salt in food preparation in 1989–90 and that 60 percent of individuals never or rarely used salt at the table during a similar time period (1989–91). The 1993 National Health Interview Survey indicated that 37 percent of adults regularly purchase foods low in sodium.

Despite some positive changes in the American diet, such as the small decline in fat consumption, overweight prevalence has increased. Between 1976–80 and 1988–91, the percentage of the adult population considered to be overweight increased from 26 to 34 percent.¹ Among all ethnic and age subgroups of the population, there were

increases in overweight. Comparisons of self-reported overweight data with actual measurements of height and weight show that people tend to underreport their weight. Therefore, the need for actual measurements of weights and heights to assess the prevalence of overweight takes on even greater importance.

Fewer overweight people appear to be taking steps to control their weight by consuming fewer calories and exercising more. Despite concern about these trends in weight-loss practices and overweight prevalence, there is optimism in this emerging message: even modest reductions in weight can confer health benefits and enhance a person's sense of well-being. For example, weight loss that occurs as a result of diet and increased physical activity will help lower blood pressure and blood cholesterol levels and improve insulin sensitivity and glucose homeostasis or control.

Settings such as schools, supermarkets, restaurants, the workplace, and health care offices are targets for several of the HEALTHY PEOPLE 2000 nutrition objectives. According to a National Restaurant Association survey, the proportion of restaurants offering low-fat, low-calorie food choices increased from 70 percent in 1989 to 75 percent in 1990. Also, more processed food products that are reduced in fat are available in supermarkets. Data from the Nielsen Company National Scantrack showed 2,500 such products in 1986, compared with more than 5,600 in 1991. There was a small increase in food label use by adults from 74 percent in 1988 to 76 percent in 1990 according to the Health and Diet Survey. The 1993 National Health Interview Survey showed 66 percent of adults read food labels for calories, fat, and/or cholesterol.

Efforts to provide school meals consistent with the *Dietary Guidelines* are falling short of the target set for objective 2.17. Only 1 percent of schools offered lunches providing an average of 30 percent or less of calories from fat. To improve school meals, USDA mounted a comprehensive *School Meals Initiative for Healthy Children* in June 1994. Work is underway to update nutrition standards and menu planning in school programs by 1998. A school-based health promotion program developed by the National Heart, Lung, and Blood Institute provided materials and training for food service staff to meet the objectives for school meals established by USDA. This effort involved some 5,000 students in 96 schools in four States.

The proportion of worksites offering nutrition education has increased from 17 percent in 1985 to 31 percent in 1992. The proportion with weight control programs increased from 15 to 24 percent over this 7-year period.

Health professionals are a source of nutrition education and counseling, helping all individuals become aware of and implement the *Dietary Guidelines* and helping those with certain health conditions undertake therapeutic diets. In addition, providers such as obstetricians, pediatricians, and nurse practitioners can educate women of childbearing age on choosing healthy diets, new mothers about breastfeeding their infants, and children on healthful food choices to support growth and development. The 1992 Primary Care Providers Survey indicates that inquiries about diet and

nutrition were highest among pediatricians (53 percent) and nurse practitioners (46 percent) and lowest among family physicians (19 percent) and obstetricians/gynecologists (15 percent).

For older adults, objective 2.18 measures the percent of people 65 and older who receive home food services because they have difficulty in preparing their own meals or are otherwise in need of home-delivered meals. According to the 1991 National Health Interview Survey, only 7 percent of this population is being reached.

No data were available to update progress on the objectives for iron deficiency (2.10), baby bottle tooth decay (2.12), and the proportion of schools offering nutrition education (2.19).

1995 Revisions

In addition to measuring average fat intake by the U.S. population, objective 2.5 has been supplemented with a measure of the proportion of people who meet the average daily goals of the *Dietary Guidelines* for fat and saturated fat intake as a percentage of calories. The year 2000 target of at least 50 percent of the population aged 2 and older meeting these recommendations is established based on data indicating that 21 to 22 percent of the population met each of the average daily goals.

With the revision of the population group to include people aged 2 and older, objective 2.6 becomes consistent with the *Dietary Guidelines* and *Food Guide Pyramid*. The baseline data have been revised to reflect results from the 1989–91 USDA CSFII, which used an improved method for measuring the number of servings that also considers the intake of fruits, vegetables, and grain products as ingredients in mixed dishes.

In addition to measuring average intake of fruits/vegetables and grain products by the population, objective 2.6 has been supplemented with a measure of the proportion of people who meet the average daily goals of the *Dietary Guidelines* for the number of servings of these products.

The year 2000 target of at least 50 percent of the population meeting the recommendation of five or more daily servings of fruits and vegetables is based on about 30 percent of the population meeting the recommendation. The year 2000 target for the percent of the population meeting the recommendation of six or more daily servings of grain products is established at 50 percent (baseline data from the 1989–91 CSFII showed 40 percent).

To cover more completely the target population for the recommendations in the *Dietary Guidelines* and *Food Guide Pyramid*, objective 2.8 has been supplemented with a measure of consumption of calcium-rich foods by people aged 2–10. Another revision to this objective, a change to people aged 11–24, is consistent with the age

grouping for the Recommended Dietary Allowance for calcium of 1,200 mg.⁷ Because adolescent and young adult females, in particular, should increase food sources of calcium in order to decrease risk of osteoporosis in later life, a special population target is established for females aged 11–24.

The original baseline for this objective was calculated from 1-day dietary data, and the dairy product category did not consider milk and milk products from some food mixtures such as pizza and macaroni and cheese. The revised baseline estimates the number of servings of milk and milk products according to the *Food Guide Pyramid*, including milk and milk products in food mixtures, and is based on multiple days of dietary data (3 days).

The 1995 revisions also include the addition of special population targets for objectives to reduce cancer deaths, to reduce overweight prevalence, to increase the adoption of appropriate weight-loss practices, and to adopt infant feeding practices to reduce baby bottle tooth decay.

Six objectives from other priority areas have been added to the Nutrition priority area, recognizing that diet can contribute to the prevention of these diseases. Other midcourse revisions were made to the nutrition objectives and accompanying text to identify baseline data where previously lacking and to define measurements for certain objectives.

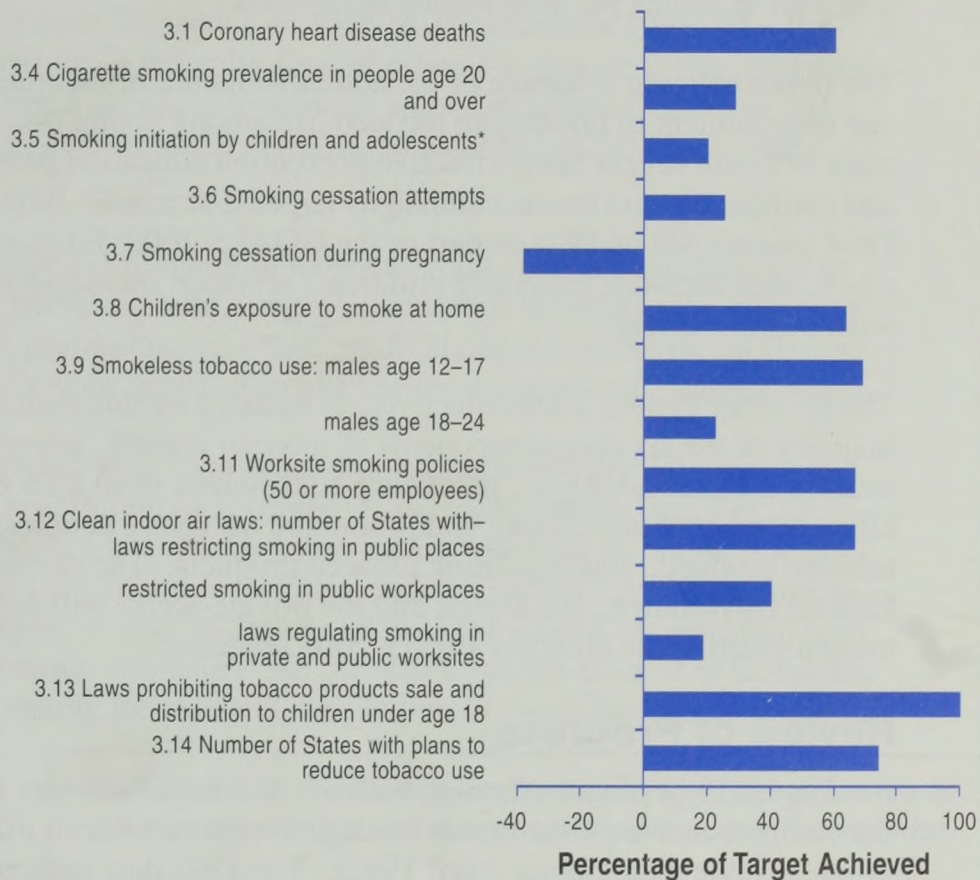
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3

Tobacco

Status of Tobacco Objectives



The percentage of target achieved cannot be calculated for objectives 3.2 and 3.3.

Tracking data for objectives 3.10, 3.15 and 3.16 are unavailable.

*See text on page 36.

Lead Agency: *Centers for Disease Control and Prevention*

TOBACCO

Use of tobacco products is the leading preventable cause of death in the United States, accounting for more than 400,000 deaths each year or about one out of every five deaths.¹ Smoking substantially increases the risk of cardiovascular disease, accounts for about 30 percent of all cancer deaths,² is the leading cause of chronic lung disease, and contributes significantly to low birthweight. Furthermore, exposure to environmental tobacco smoke (ETS) is responsible for approximately 3,000 lung cancer deaths per year among nonsmokers.³

The overwhelming evidence of the addictive nature of nicotine necessitates a continued commitment to preventing tobacco use among young people through enforcement of youth access laws, effective prevention education programs in the schools and community, and media campaigns targeted at youth. With the passage of the Pro-Children Act of 1994 as part of the GOALS 2000: Educate America Act, federally funded facilities providing children's services, including schools and libraries, must be smokefree.

The HEALTHY PEOPLE 2000 objectives, as updated by this midcourse review, cover the majority of the six core components of tobacco control: preventing tobacco use, treating nicotine addiction, protecting nonsmokers from ETS exposure, limiting the effect of tobacco advertising and promotion on young people, increasing the price of tobacco products, and regulating tobacco products. The combined efforts of the Federal Government, the States, and the private sector will help continue progress toward meeting the HEALTHY PEOPLE 2000 objectives.

Review of Progress

An August 1994 progress review with the Assistant Secretary for Health examined the comprehensive public health strategy to reduce tobacco use (the previous progress review took place April 1992). The 1993 data indicate that adult cigarette smoking prevalence has dropped to 25 percent. For certain population groups, particularly American Indians/Alaska Natives, blue-collar workers, and military personnel, the rates of smoking prevalence are considerably higher than those for the population as a whole. Limited progress has been made in reducing the proportion of people aged 20–24 who have begun to smoke cigarettes, a proxy measure of youth initiation. The rate dropped from 30 percent in 1987 to 27 percent in 1993. Among lower socioeconomic status youth the proportion declined from 40 percent in 1987 to 38 percent in 1993. Another survey, the 1994 Monitoring the Future Survey, indicated that there has been no decline in smoking prevalence among high school seniors over the last decade and an increase in smoking prevalence since 1991. The percentage of adult cigarette smokers who stopped smoking for at least 1 day during the preceding year increased from 34 percent in 1986 to 38 percent in 1993. However, among female cigarette smokers, the percentage who quit during pregnancy is moving away from the year 2000 target of 60 percent; in 1985, 39 percent quit, compared with 31 percent in 1991. Among women with less than a high school

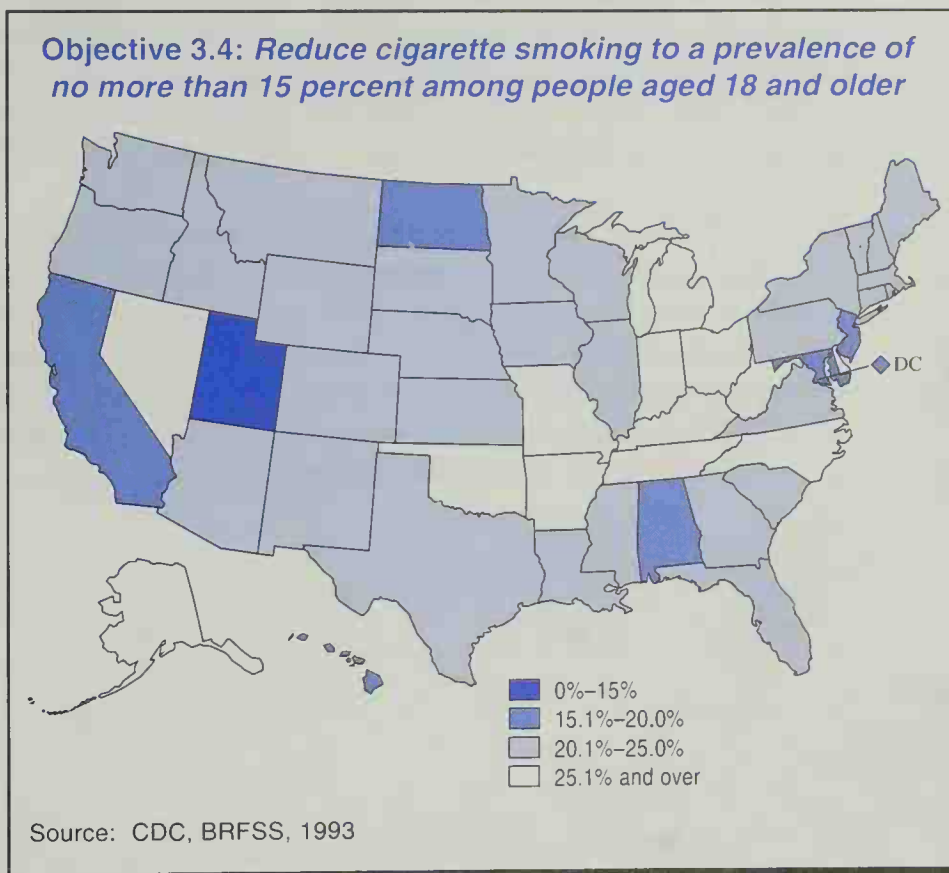
education, 28 percent quit in 1985, compared with 21 percent in 1991. For males aged 12–17, smokeless tobacco use has declined from 6.6 percent in 1988 to 3.9 percent in 1993. Among males aged 18–24, a decrease from 8.9 percent in 1987 to 7.8 percent in 1993 has occurred. For American Indian/Alaska Native males, the comparability and small sample size of the data on smokeless tobacco makes identifying trends difficult.

The number of children aged 6 and younger who are regularly exposed to tobacco smoke at home declined from 39 percent in 1986 to 27 percent in 1993. The Pro-Children Act of 1994, requiring federally funded schools to be smokefree, promotes the elimination of children's exposure to tobacco smoke in schools. In 1994 the District of Columbia and 41 States had plans to reduce tobacco use, particularly among young people.

Data for tracking objective 3.15 regarding tobacco product advertising targeted to youth are unavailable. However, continued attention must be paid to the effects of tobacco advertising and promotions on youth, particularly due to the recent finding that youth are more likely than adults to smoke the most advertised cigarette brands.⁴

A 1992 survey of employers with 50 or more employees found that 59 percent had policies in place either prohibiting or severely restricting smoking. In 1994 the District of Columbia and 41 States had laws restricting smoking in public places; 38 States and the District of Columbia had laws and/or executive orders restricting smoking in public workplaces; and 18 States and the District of Columbia had laws regulating smoking in private worksites. All 50 States and the District of Columbia have enacted laws prohibiting the sale and distribution of tobacco to youth under age 18. Although progress has been made toward achieving the year 2000 target for tobacco on the State level, many of these laws contain preemption clauses that prohibit local governments from enacting more stringent policies.

A 1992 Primary Care Providers Survey found that 33 percent of pediatricians routinely inquired about tobacco use, while 19 percent provided cessation counseling. Among



internists, 75 percent routinely inquired about tobacco use; whereas 50 percent discussed strategies for quitting.

Mortality data demonstrate the results of decreased tobacco use. The coronary heart disease death rate has been reduced from 135 per 100,000 population in 1987 to 114 in 1992. The rate for blacks declined from 168 per 100,000 population in 1987 to 151 in 1992, but this decline is not sufficient to narrow the gap with the total population. The lung cancer death rate has risen slightly from 38.5 per 100,000 population in 1987 to 39.3 in 1992. The chronic obstructive pulmonary disease death rates have increased slightly from 18.9 per 100,000 population in 1987 to 19.9 in 1992.

1995 Revisions

Among the four new objectives added to the Tobacco priority area, one seeks to increase the average (State and Federal combined) tobacco excise tax to 50 percent of the retail price. Another seeks to increase to 100 percent the proportion of health plans that cover treatment of nicotine addiction. There is a new objective to reduce the number of States with clean indoor air laws that preempt stronger clean indoor air laws on the local level. Another new objective was added to supplement objective 3.13 to increase the number of States with laws restricting youth access to tobacco vending machines.

Special population targets have been added to objective 3.2 for females and black males to address the disparity in lung cancer deaths. For objective 3.4, reducing smoking prevalence, the age range was lowered from 20 to 18 years to focus attention on smoking at an earlier age. The language in objective 3.12 has been revised to specify that smokefree indoor air laws either ban or limit smoking to separately ventilated areas. New language has been added to objective 3.13 to measure the enforcement of laws prohibiting the sale and distribution of tobacco products to youths. The District of Columbia was added to the jurisdictions in which legislative action is sought in several objectives (objectives 3.12, 3.13, and 3.14).

Several objectives from other priority areas have been added as shared objectives to the Tobacco priority area. These objectives address the average age of first use of cigarettes by adolescents aged 12–17, oral cancer deaths, and stroke deaths. Because cigarettes have been added to the list of substances in three objectives in the Substance Abuse: Alcohol and Other Drugs priority area (use in the past month, perception of social disapproval, and perception of harm), these objectives are being added as shared objectives to the Tobacco priority area.

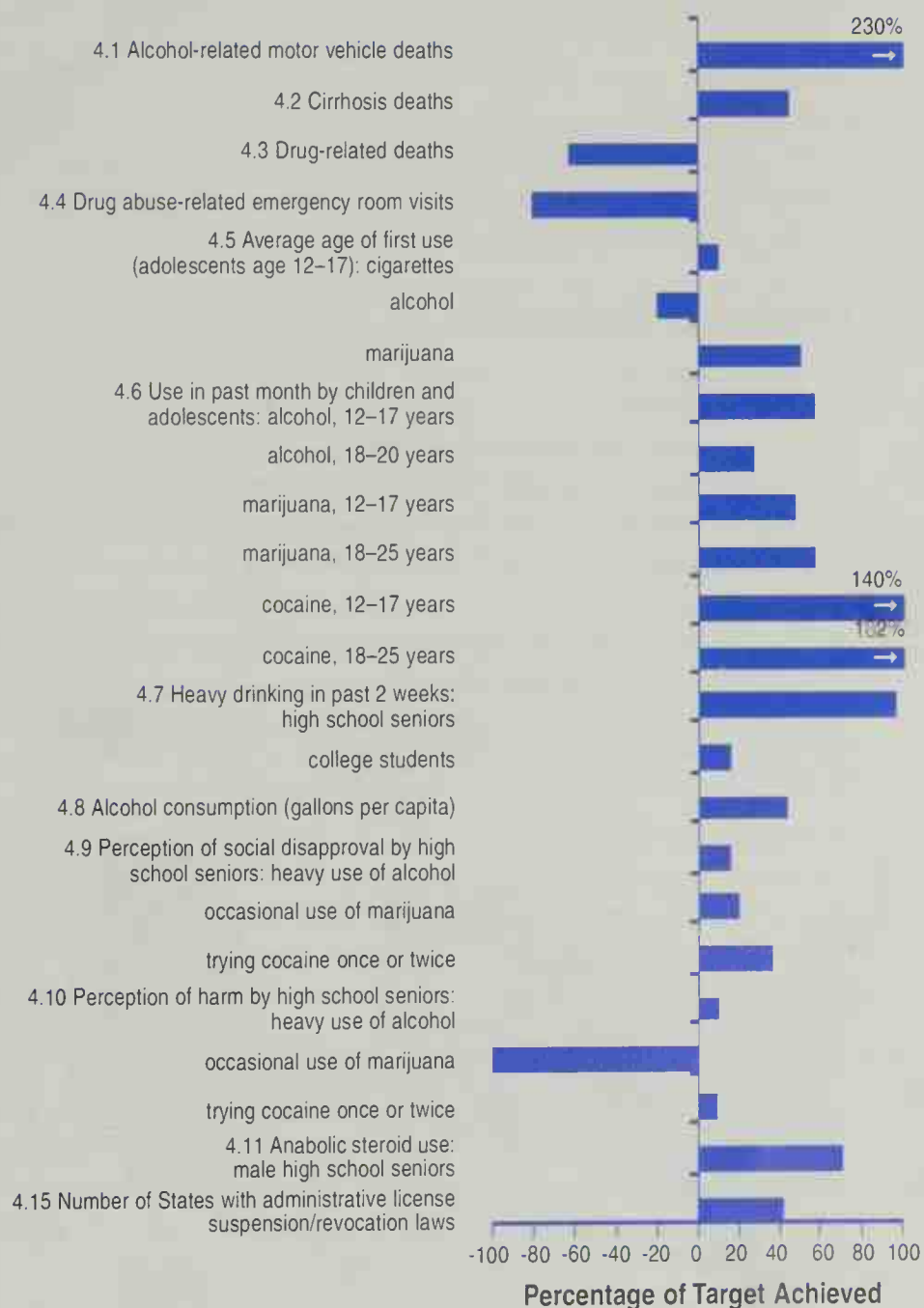
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4

Substance Abuse: Alcohol and Other Drugs

Status of Substance Abuse: Alcohol and Other Drugs Objectives



Tracking data for objectives 4.12-4.14 and 4.16-4.19 are unavailable.

Lead Agency: *Substance Abuse and Mental Health Services Administration*

SUBSTANCE ABUSE: ALCOHOL AND OTHER DRUGS

Alcohol and other drug abuse undermines citizens' health directly and indirectly. Substance abuse is estimated to be the actual cause of some 120,000 deaths per year with 100,000 attributed to alcohol and 20,000 to other drug use.¹ Alcohol and other drugs contribute to unintentional injury (particularly automobile crashes), suicide, and other violent deaths as well as being factors in a high percentage of chronic disease deaths. AIDS resulting from injecting drugs, babies born HIV-positive or exposed to crack cocaine, and drug-related violence all exact human and economic costs. An equally devastating, though less tangible effect, is the psychological, familial, and social damage that accompanies substance abuse. Serious attention to alcohol and other drug use prevention is fundamental to the control of health care costs. Because of the pervasive effects of substance abuse, effective prevention and control strategies require the collaboration of the public health, education, social service, and law enforcement sectors.

Review of Progress

The reduction of alcohol-related vehicle deaths is one of the greatest success stories of public health in this decade. From a 1987 baseline of 9.8 deaths per 100,000 people to a 1993 level of 6.8 deaths per 100,000 people, the year 2000 target of 8.5 deaths has been achieved. Success in attaining the HEALTHY PEOPLE 2000 target for alcohol-related motor vehicle crashes reflects the passage of administrative license revocation laws in 37 States and the District of Columbia and the lowering of blood alcohol concentration (BAC) tolerance levels from .10 to .08 in 11 States. Enforcement of those laws and education of individuals cited for driving while intoxicated (DWI) offenses also have played a major role. Annual per capita alcohol consumption measured for people aged 14 and older in the United States declined from 2.54 gallons in 1987 to 2.31 gallons in 1991.

When alcohol-related motor vehicle crash death rates are examined by State using 1993 data from the National Highway Traffic Safety Administration (NHTSA), 36 States had rates lower than the year 2000 target of 8.5 deaths per 100,000. In 1993, twelve States (mostly in the Northeast) and the District of Columbia met the target of 5.5 deaths per 100,000—a more challenging target that has been established as a part of the 1995 revisions.

At an October 1994 progress review with the Assistant Secretary for Health the discussion focused on adolescent substance abuse. The average age of first use of cigarettes, alcohol, or marijuana has shown little change over the past 5 years. In 1993, the average age of first use of cigarettes was 11.7; alcohol was 12.9; and marijuana was 13.9.

One strategy for addressing child and adolescent substance abuse is through alcohol and drug education in schools. Alcohol and marijuana use among adolescents (aged 12–17) declined from 1988 to 1992 according to the National Household Survey on Drug Abuse. However, this survey detected an increase in the use of these two

substances by this age group beginning in 1992. In an apparent contradiction, the 1994 Monitoring the Future Survey showed that alcohol use among high school seniors had declined to the lowest level recorded by this survey. On the other hand, this same survey showed an increase in marijuana use in 1992 that continued in 1993 and 1994. If truly reflective of the trends, these use patterns may derive from apparent declines in high school seniors' perception of social disapproval about heavy use of alcohol, occasional use of marijuana, and trying cocaine. Anabolic steroid use by high school senior males has declined in the past 4 years. Strategies for addressing child and adolescent substance abuse include education in the schools, community-focused public education campaigns, and environmental policies.

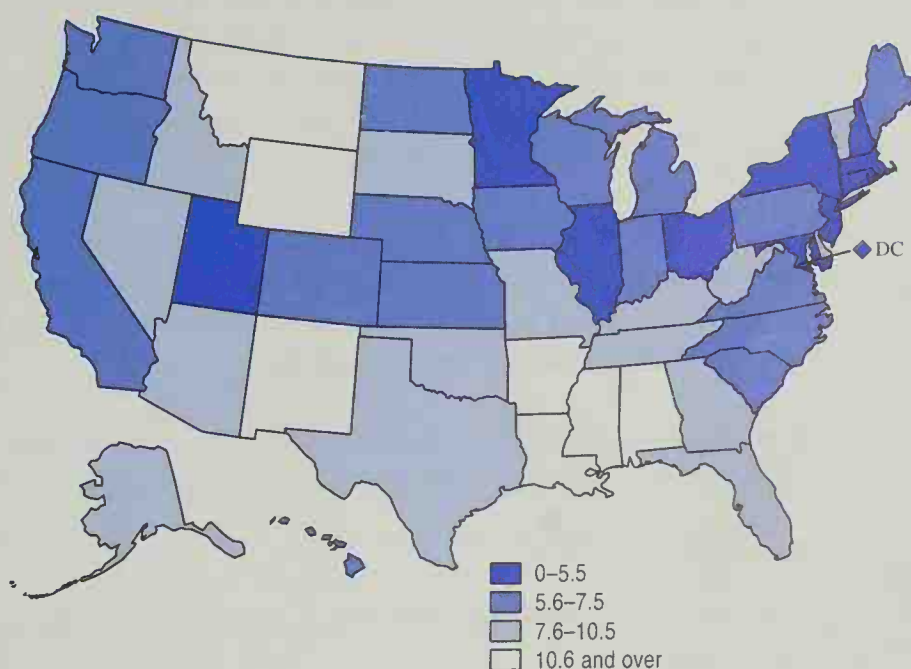
Workplace programs can be an effective way to address adult substance abuse. A 1992 survey of employers with 50 or more employees found that 88 percent had established policies addressing alcohol use at the worksite and 89 percent had set drug policies, thereby exceeding the year 2000 target for objective 4.14. The most common policies promote drug-free and alcohol-free workplaces. More than one-third of the worksites offer information and 40 percent offer employee assistance programs.

Another strategy for addressing substance abuse problems is to increase the proportion of primary care providers who screen and counsel for alcohol and other drug use problems. The 1992 Primary Care Providers' Survey established the baseline for this objective on inquiry about alcohol use and referrals; 63 percent of internists said they routinely inquire about alcohol use and 34 percent routinely inquire about drug use.

Drug abuse-related emergency room visits have risen and are moving away from the year 2000 target, as is the number of drug-related deaths which increased in 1992 to 4.3 per 100,000 population. Cirrhosis deaths declined from 9.2 per 100,000 population in 1987 to 7.8 according to provisional 1993 data.

Baselines have not been established yet for objectives 4.12, 4.16, and 4.17. Data to track these objectives are collected in State Substance Abuse Prevention and Treatment Block Grant applications. Objective 4.12 seeks to

Objective 4.1: Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 5.5 per 100,000 people



Source: NHTSA, Fatal Accident Reporting System, 1993

establish comprehensive plans at the State level to ensure access to alcohol and drug treatment programs for underserved people, including substance-abusing pregnant women, intravenous drug users, and injecting drug users with HIV infection. Objective 4.16 encourages States to adopt policies or to enact statutes to reduce access to alcoholic beverages by minors. Objective 4.17 seeks to increase the number of States with laws that restrict the promotion of alcoholic beverages to young audiences.

1995 Revisions

Because of success in reducing alcohol-related vehicle crash deaths, the targets already have been met for the total population and for people aged 15–24. Therefore, revisions are made to the target for objective 4.1 and for the special population targets to make them more challenging. The American Indian/Alaska Native men baseline has been changed to include all American Indian/Alaska Native men, not just those living in Reservation States. A new target was set. Similarly for objective 4.2, the American Indian/Alaska Native cirrhosis death baseline was changed to include all American Indians/Alaska Natives, not just those living in Reservation States. As a result, a new target was established.

Special population targets have been added to a number of objectives to narrow the gap between the total population and the particular subgroup. Cirrhosis deaths will be tracked for Hispanics. Drug-related deaths will be monitored for blacks and Hispanics.

Cigarettes have been added to the substances tracked in objectives 4.6, 4.9, and 4.10. This addition seeks to address tobacco use by young people as a gateway phenomenon to alcohol and other drug use.

One new objective has been added as a part of the midcourse review. It seeks to increase to 30 the number of States with Hospitality Resource Panels that are broadly representative of the community with alcohol industry, insurance associations, State regulatory, public health, highway safety, and law enforcement agencies defining standards for responsible hospitality.

Objective 4.18 has been revised to track State laws that lower BAC tolerance levels to .08 for adults and zero tolerance (.02) for drivers younger than 21. This revision makes the HEALTHY PEOPLE 2000 target consistent with the policies of the National Highway Traffic Safety Administration.

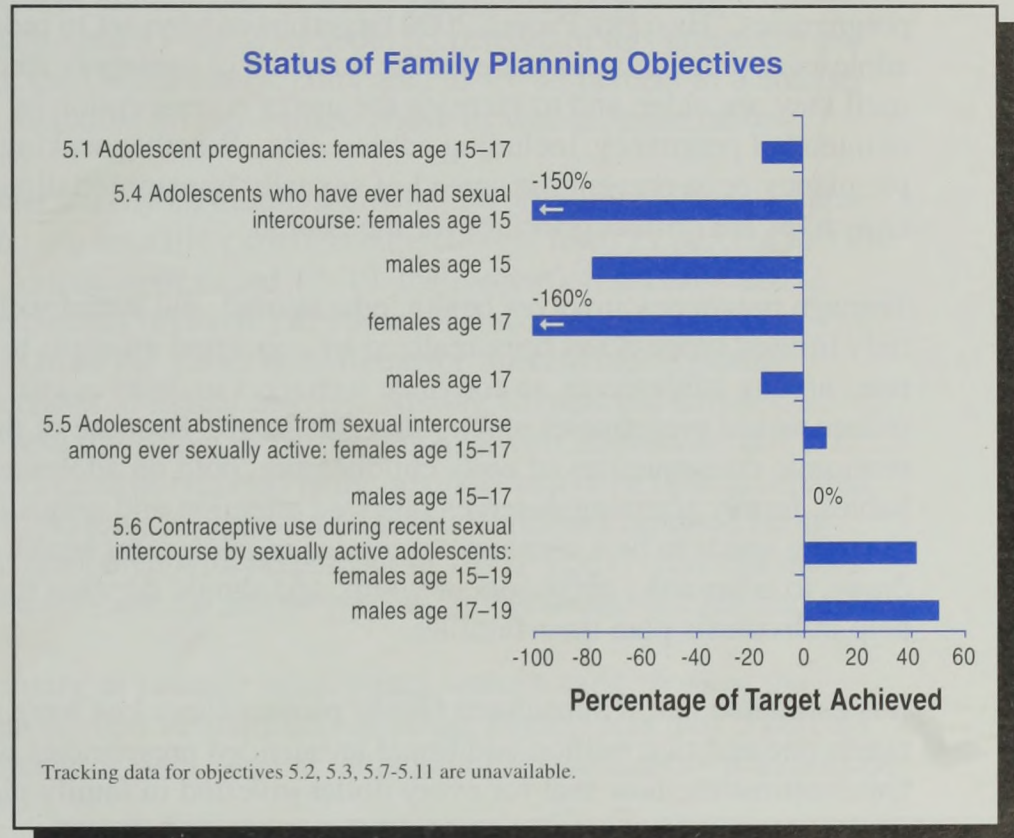
The priority area name has been revised from Alcohol and Other Drugs to Substance Abuse: Alcohol and Other Drugs to emphasize the problem of illegal drug use.

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5

Family Planning



Lead Agency: *Office of Population Affairs*

FAMILY PLANNING

Family planning provides individuals with the information and services they need to make informed choices about whether and when to become parents. Family planning services include counseling and medical services that are important determinants of the health and well-being of individuals, particularly women, and of healthy pregnancies. HEALTHY PEOPLE 2000 targets have been set to reduce the incidence of adolescent pregnancy, to increase the numbers of teenagers who delay sexual activity until they are older, and to increase the use of contraception by all women at risk of unintended pregnancy, including adolescents. Whether seeking to avoid unintended pregnancy or to prevent the spread of sexually transmitted diseases, family planning objectives are critical priorities for the Nation.

Teenage pregnancy involves health, educational, and social welfare issues. So far, only limited success has been realized by concerted attempts to reduce pregnancy rates among adolescents, to convince teenagers to delay sexual activity, and to reduce repeat pregnancies among this age group. Because of the serious social and economic consequences of early childbearing, both on adolescent parents and their babies, family planning deserves renewed attention and unqualified support. Family planning needs to be a cornerstone service of adolescent health care, with a link drawn to other risky behaviors of youth, and should do what the name suggests—help individuals plan their families.

It is estimated that if subsidized family planning services were not available, between one and two million additional unintended pregnancies would occur each year. Other estimates show that for every dollar invested in family planning, \$4.40¹ in welfare and medical service expenditures is avoided.

With access to family planning, adults can plan the number of and space the intervals between children. Research showing that low birthweight may be linked to insufficient spacing between children reinforces the importance of ensuring such access.

Review of Progress

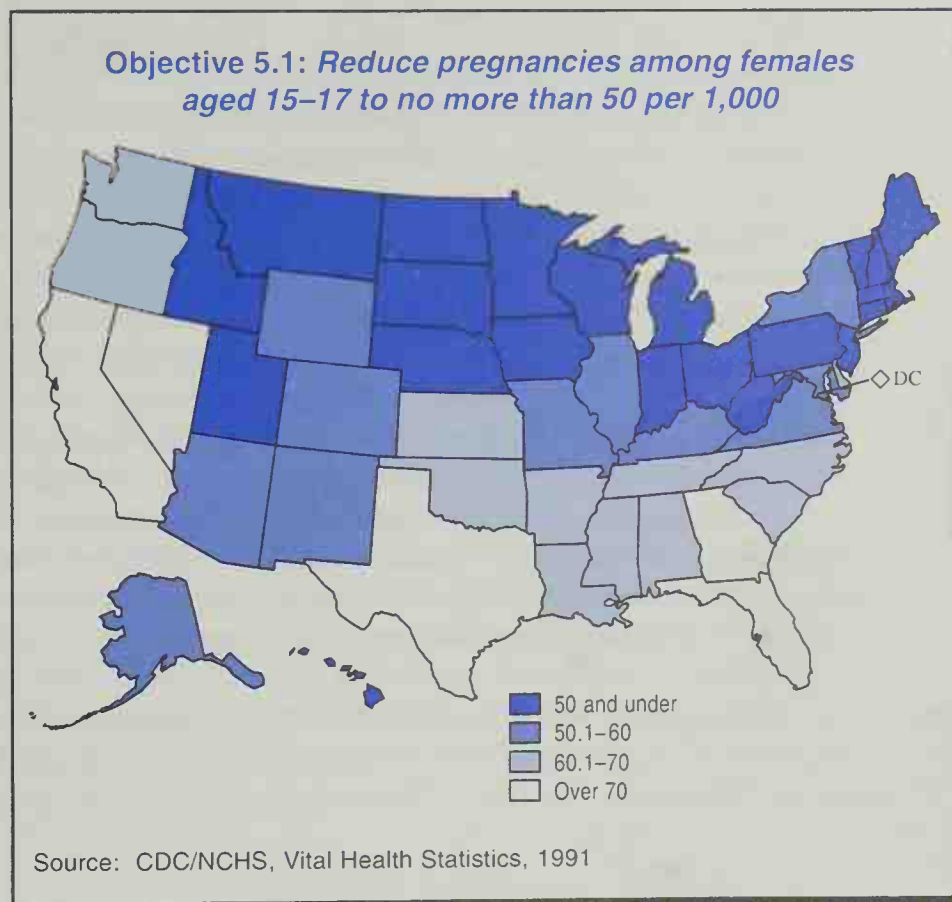
The data used to establish baselines for the initial tracking of the family planning objectives are from the 1980s. In 1988, 67 percent of all women aged 15–44 were considered to be at risk of unintended pregnancy; the proportion not using a contraceptive method was approximately 10 percent. Even this apparently small proportion is important—in absolute numbers this means an estimated 4 million women were at risk of unintended pregnancies. The proportion not using a method of contraception is even higher among some population subgroups. Only 85.3 percent of women whose income fell below 200 percent of the poverty line and only 80.2 percent of the women below 100 percent of the poverty line used contraception in 1988. Thus, nearly 20 percent of the Nation's lowest income women at risk of unintended pregnancy used no form of contraception. Among poor teenagers, the proportion was 25 percent.

Data for the early 1980s show that among married or cohabiting women aged 20–29 and 35–44, use of any method of contraception was somewhat lower in the United States than in other developed countries. In the United States 68 percent of married or cohabiting women aged 20–29 use a contraceptive method, compared to 76 percent in Greece and the Netherlands, 73–74 percent in Finland, France, Norway, and Portugal, and 72 percent in Italy and the United Kingdom. Even larger differences exist among women aged 35–44, with about 63 percent of this group using a contraceptive method in the United States, compared to 75–83 percent in a number of European countries, including all those listed above as well as some others.¹

According to the National Survey on Family Growth, the proportion of adolescent females aged 15–17 who are sexually experienced increased from 29 percent in 1970 to 52 percent in 1988. Among males aged 17–19, the proportion sexually active increased from 66 to 76 percent between 1979 and 1988 according to the Survey of Adolescent Males. Data from the Youth Risk Behavior Surveillance System (YRBSS) also show increases in sexual activity. Among 15-year-old females, 27 percent reported being sexually active in 1988 compared with 36 percent in 1991. For 15-year-old males, 33 percent reported being sexually active in 1988 compared with 44 percent in 1991. Among 17-year-old females, 50 percent reported being sexually active in 1988, compared with 66 percent in 1991. For 17-year-old males, the proportion sexually active was 66 and 68 percent, respectively, in 1988 and 1991.

Sexual initiation is occurring at younger ages: young women aged 15 show the largest increase in the proportion sexually active—from slightly less than 5 percent in 1979 to nearly 26 percent in 1988. Age at initiation of sexual activity is important because when first intercourse is early, contraceptive use is lower and pregnancy risk higher. Younger black women are more likely to be sexually active than their white counterparts. The difference between the two races is narrowing; however, the increases in adolescent sexual activity observed during the past decade are much greater for whites.

Efforts in the United States to prevent adolescent pregnancy have taken a number of forms—sex education,



abstinence education, life skills education, contraceptive education, and contraceptive services programs—both singly and in combination. During the past decade, the primary Federal focus to prevent adolescent pregnancy has been abstinence education. Despite the requirement that such programs be evaluated, there is little evidence of their success or failure—with the exception of apparent increases in knowledge among those who participate in the programs.

Fewer than 10 percent of children receive comprehensive sexuality education programs.² “Youth at Risk,” a report by Population Action International, a nonprofit family planning advocacy group, concluded that the school systems of most countries have largely failed to meet the sexual health education needs of youth. The reasons: societal discomfort in acknowledging adolescent sexual activity and the misconception that access to sexuality education or contraception promotes sexual activity among youth. A report by the World Health Organization stated there is no evidence that sex education in schools leads to earlier or increased sexual activity among young people. The review of 35 studies indicates sex education is most effective when given before a young person becomes sexually active and programs that promote both postponement of sex and protected sex are more effective than those that promoted abstinence alone.⁴

In its 1993 assessment of State sexuality education programs, the Sex Information and Education Council of the United States (SIECUS) found 48 States either recommend or require sexuality education through State law or policy (38 States have developed State sexuality education curricula). SIECUS also found that sexuality education most typically falls under health education; only 24 States have an identified staff person who is in charge of sexuality education; only 9 States require specific training as a condition of teaching sexuality education; and only 14 States require sexuality teachers to be certified in a specific field. Thirty States have school/community advisory committees to develop, review, or recommend appropriate sexuality education materials and concepts to be taught at various grade levels.³

Three relatively new sexuality education curricula have shown promising results with respect to delay of sexual activity as well as increased contraceptive uses when sexual activity is initiated.^{4,5,6} All three programs include information about sexuality and contraception, as do most traditional sexuality education programs. The important difference is that they also include training in decisionmaking and resistance skills, and practice in applying those skills. These programs appear to be more effective with younger adolescents and with those who have not yet initiated sexual activity, providing support for the argument that sexuality education should begin earlier than currently is the norm. Another study has shown that young men who reported receiving instruction in resistance skills had lower rates of sexual activity than those who did not receive such instruction.⁷

The proportion of young people who choose abstinence has increased. In 1988 an estimated 23.6 percent of ever sexually active females, aged 15–17, abstained from sexual intercourse. In 1991, 25 percent abstained from sexual intercourse. Among

adolescent males, the percent increased from 33 percent in 1988 to 36 percent in 1991.

Counselors and educators should be trained in building skills to help young people who choose abstinence to sustain their choice. Educational materials and counseling should give credence and support to abstinence as a healthy choice. Peer groups advocating abstinence also should be encouraged. The consequences of nonmonogamous sexual intercourse can include elevated risk of acquiring one or more sexually transmitted diseases (STDs), including HIV infection. In addition, some STDs have lasting negative effects on fertility. Therefore, abstaining from sexual intercourse is a preferable prevention choice, especially for adolescents.

Among sexually active adolescents, contraceptive use has increased, as measured by use of a contraceptive method at most recent intercourse. For females aged 15–19, 78 percent used contraception in 1988, compared with 81 percent in 1991. For high school males, contraceptive use at most recent intercourse increased from 78 percent in 1990 to 83 percent in 1991.

Despite increases in abstinence and increased use of contraceptive methods, adolescent pregnancy rates have increased. In 1985, the pregnancy rate for females aged 15–17 was 70.9 per 1,000 females; in 1990 the rate was 74.3. Over this same time period, live births for this age group increased from 31 to 37.5 per 1,000 adolescent females, while abortions declined from 30.6 to 26.5 per 1,000 adolescent females. Fetal losses account for the remaining pregnancies. Among black teens 15–17, the pregnancy rates increased from 134 to 140 per 1,000 black females between 1985 and 1988.

A 1992 Primary Care Providers' Survey provides a picture of the extent to which clinicians are routinely inquiring (of 81–100 percent of patients) about family planning for females of childbearing age or providing counseling about family planning. Among pediatricians, 18 percent reported that they routinely inquire about family planning, while 36 percent reported that they routinely counsel about family planning. For other providers the findings were: family physicians, 28 percent and 36 percent; obstetricians/gynecologists, 48 percent and 65 percent; nurse practitioners, 53 percent for both.

No data beyond the baseline are available to track unintended pregnancy, infertility, failure of contraceptive method, family discussion of human sexuality, information from counselors, and clinic services for HIV infection and STDs. The data for tracking most of these objectives will be included in the 1995 cycle of the National Survey of Family Growth. The 1994 cycle of the National Survey of Adolescent Males will provide information on a population of in- and out-of-school males aged 15–19. In the interim, information from CDC's Youth Risk Behavioral Surveillance System provides useful tracking data, although this biennial survey only captures in-school youth.

1995 Revisions

A new objective was added to track the use of contraception by women at risk of unintended pregnancy. The objective is aimed at increasing to at least 95 percent the proportion of women (aged 15–44) at risk of unintended pregnancy who use contraception. Special population targets for low-income women seek to narrow the gap between poor and nonpoor women who use contraception.

Objective 5.1 has been revised to focus on females aged 15–17 because the consequences and implications of pregnancy are most severe for adolescents. The number of pregnancies to adolescents under age 15 is small, making it difficult to measure trends. Adolescents over age 17 are considered legally to be adults. The consequences of unintended pregnancy among females aged 15–17 and the implications for their children's lives are long-lasting. In objective 5.6, the age groups also have been modified to measure the proportion of sexually active, unmarried people aged 15–24 (measured in two age groupings: 15–19 and 20–24) rather than just adolescents aged 19 or younger. The objective has been expanded to measure the 20- to 24-year-old population because unprotected sexual intercourse puts many of these young adults at risk of unintended pregnancy, STDs, and HIV infection.

Special population targets were added to several objectives. A Hispanic subobjective was added to objective 5.2. Black males aged 15, black males aged 17, and black females aged 17 were established as special population targets for objective 5.4 to reduce the proportion of adolescents who have engaged in sexual intercourse.

The target in objective 5.7 was adjusted proportionately to a new baseline. The objective tracks the percent of women rather than couples who experience pregnancies despite the use of a contraceptive method. Black and Hispanic special population targets have been established for this objective.

The scope of objective 5.9 has been expanded to measure the proportion of family planning counselors who offer to their patients with unintended pregnancies balanced, complete, and accurate information about all pregnancy options, including prenatal care and delivery, infant care, foster care, adoption, and pregnancy termination. The provision of information on only one option is not sufficient for a patient to make an informed choice. The revised objective is a more appropriate measure to assess the extent of counseling services offered by public health professionals in family planning settings.

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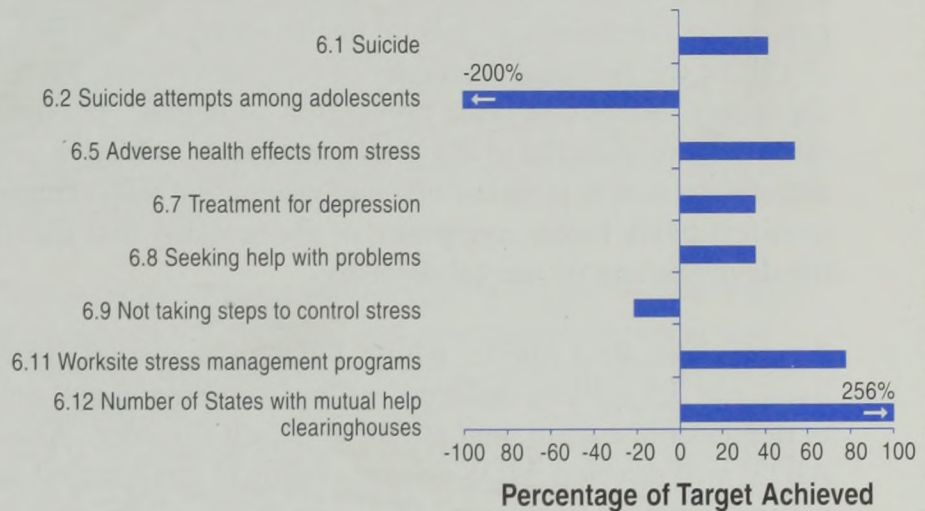
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6

Mental Health and Mental Disorders

Status of Mental Health and Mental Disorders Objectives



Tracking data for objectives 6.3, 6.4, 6.6, 6.10, 6.13, and 6.14 are unavailable.

Lead Agencies: *Substance Abuse and Mental Health Services Administration*
National Institutes of Health

MENTAL HEALTH AND MENTAL DISORDERS

Prevention of mental disorders and promotion of mental health has a long history. The framework of primary, secondary, and tertiary prevention dates back to the 1957 Commission on Chronic Illness. The National Mental Health Association report in 1986, *The Prevention of Mental-Emotional Disabilities*,¹ defined prevention as “intervening in a deliberate and positive way to counteract harmful circumstances before they cause disorder or disability.” A National Prevention Coalition was established in 1987 to promote the acceptance and use of prevention services as a part of the continuum of mental health services. In 1993, the Institute of Medicine (IOM) of the National Academy of Sciences report, *Reducing Risks for Mental Disorders*,² identified three prevention strategies: universal low-cost preventive interventions directed at the total population; selective preventive interventions targeted to at-risk populations; and preventive interventions for individuals who manifest a risk factor, symptom, or abnormality that identifies them at high risk for the development of mental disorders.

An estimated 41.4 million adults³ have had a mental disorder at some time in their lives, and 7.5 million children⁴ suffer from mental and emotional disturbances such as depression, autism, and attention deficit disorder. About one-fifth of people with AIDS⁵ will develop AIDS-related cognitive dysfunction and two-thirds will develop neuropsychiatric problems.⁶ Only one in six adults⁷ with serious mental health problems gets needed care and only about one-third of children⁸ receive services.

The societal costs of mental illness are considerable—\$74.9 billion in 1990.⁹ Major depression accounts for more bed days than any impairment except cardiovascular disorders.¹⁰ People with job-related stress, anxiety, and depression miss an average of 16 work days annually.¹¹ People with untreated mental illnesses consume almost twice as much medical care as the average individual.¹²

The Center for Mental Health Services (CMHS) of the Substance Abuse Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH)/National Institute of Mental Health (NIMH) have conducted special activities that facilitate progress on HEALTHY PEOPLE 2000 mental health objectives. SAMHSA/CMHS sponsored a conference on prevention services in 1993 that identified the need for improved coordination between the mental health, health, and welfare sectors. NIH/NIMH has sponsored annual national prevention research conferences since 1990; in these conferences the state of development of intervention models in selected areas was reviewed and related recommendations made for strengthening the research, training prevention scientists, and improving the organization of the scientific effort. The congressionally mandated IOM report identified 39 preventive intervention programs based on rigorous research methodologies that can now be tested under different population and systemic conditions. About three-quarters of these models address behavioral, emotional, and learning problems of children and adolescents through risk reduction and developmental enhancement, most of which

*In May 1995 NIMH was recognized as the co-lead for the Mental Health and Mental Disorders priority area.

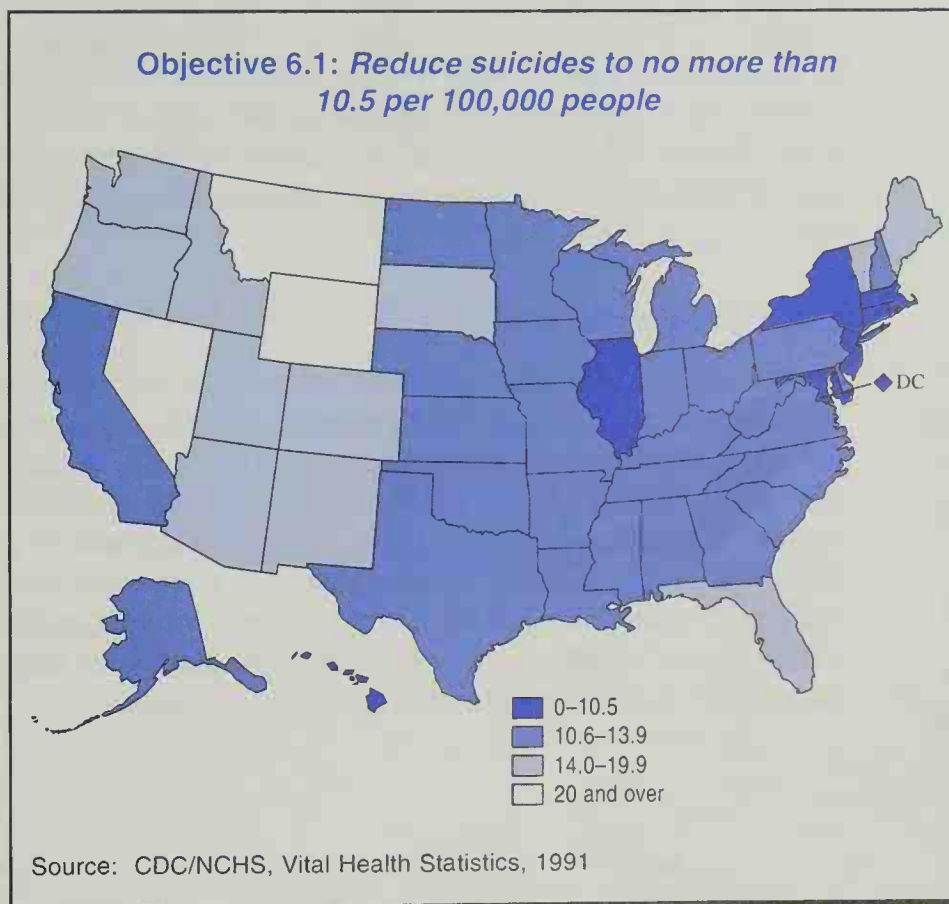
relied on health, preschool or school interveners. The model program interventions with children and adolescents include: high quality prenatal and perinatal care; childhood immunizations; home nurse visitation for improved parenting; intensive and prolonged center-based early childhood education combined with home visitation; center-based early childhood education starting to improve parenting and enhance behavioral or cognitive development from infancy onward; multiple strategies to enhance self-regulation and interpersonal as well as cognitive skills of elementary school children; the use of specific instructional methods in classrooms and individual tutoring to reduce learning problems; enhancement of various family stress coping skills during the elementary school years; normative changes strategies in school and peer settings to reduce early substance abuse by adolescents or community norms toward aggression; and risk factor reduction through alterations in the nature and structure of schooling and school experiences or empowerment of school communities in initiating such alterations.

CMHS initiated this year a focus on prevention services for 0–7-year-olds in multi-agency child and adolescent programs for planning and system development and services implementation. In 1994 SAMHSA/CMHS spent approximately \$10 million in support of prevention demonstrations and training activities. NIMH estimates 1993 expenditures totaling \$43.9 million on research on the reduction of disorders addressed in the HEALTHY PEOPLE 2000 Mental Health priority area.¹³ Other prevention research focuses on physical or behavioral outcomes to which mental disorders contribute or antecedents to known causes of mental disorders that are addressed in \$17.9 million of expenditures in other HEALTHY PEOPLE 2000 priority areas.¹⁴

The NIH Depression Awareness, Recognition, and Treatment (D/ART) program educates the public, primary care providers, and mental care providers about depression. D/ART's primary goals are to help people recognize the symptoms of depression and to encourage individuals to seek help.

Review of Progress

More than 30,000 suicides occur each year. The ninth leading cause of death in 1992, suicide is



the third leading cause of death among adolescents and young adults aged 15–24. Adults over the age of 65 have high suicide death rates; in 1992, 16.5 per 100,000 population. The rates increase substantially to 22.8 per 100,000 among people over 85 years of age.

Since 1987, the rate of suicides has declined; the percentage of people seeking help for mental problems has risen; and the percentage of people in treatment for depression has increased. Suicide attempts by adolescents have, however, increased. The increase may be linked to improved reporting and recognition of injurious suicide attempts as well as possible increases in substance abuse. There are no new data to estimate the overall prevalence of mental disorders among children or adults.

The workplace has become an important site to address mental health issues. In 1992, 37 percent of employers with 50 or more employees offered information, resource materials, group classes, or lectures to reduce employees' stress. Individual counseling was offered by 27 percent of employers. The use of community support programs and the number of States with suicide prevention in the jails have no data updates.

The 1992 Primary Care Providers' Survey provides baseline data on the extent to which providers are routinely reviewing patients' mental functioning. For adults, the survey shows that counseling is not widespread. The results for children are more promising. Among pediatricians 62 percent routinely inquired about cognitive function; 55 percent reported routinely inquiring about parent-child relationships; and 47 percent inquired about emotional/behavioral functioning. As for treatment referrals, the pediatricians reported routinely referring 51 percent of patients for cognitive problems, 45 percent for emotional/behavioral problems, and 34 percent for treatment of parent-child relationships. For adults, 40 percent of nurse practitioners reported inquiring about emotional/behavioral function and 35 percent inquired about cognitive functioning; among internists the level of counseling was 25 and 18 percent respectively. Obstetricians/gynecologists and family physicians reported even lower levels of inquiry.

1995 Revisions

A new objective on depression has been added with a special population target for women. Research shows that depression is often comorbid with other psychiatric and physical illnesses. Depression is one of the strongest risk factors for attempted and completed suicides. Primary care physicians often fail to recognize the symptoms of depression in their patients, and the symptoms of depression often mimic those of physical illnesses. Depression is a significant public health problem with potentially fatal consequences to its victims. Approximately 80 percent of patients¹⁵ can be treated successfully, yet less than 40 percent of individuals with depression have seen a health care provider about their illness.¹⁶

A new baseline and target include expanded diagnostic criteria for children and adolescents for objective 6.3. The revised rates are population based and more accurately reflect the estimated prevalence of mental disorders in this age group.

Objective 6.12 has been revised to recognize that networked communications make the linkage of Federal and State self-help information, resources, and activities more effective than State self-help clearinghouses alone.

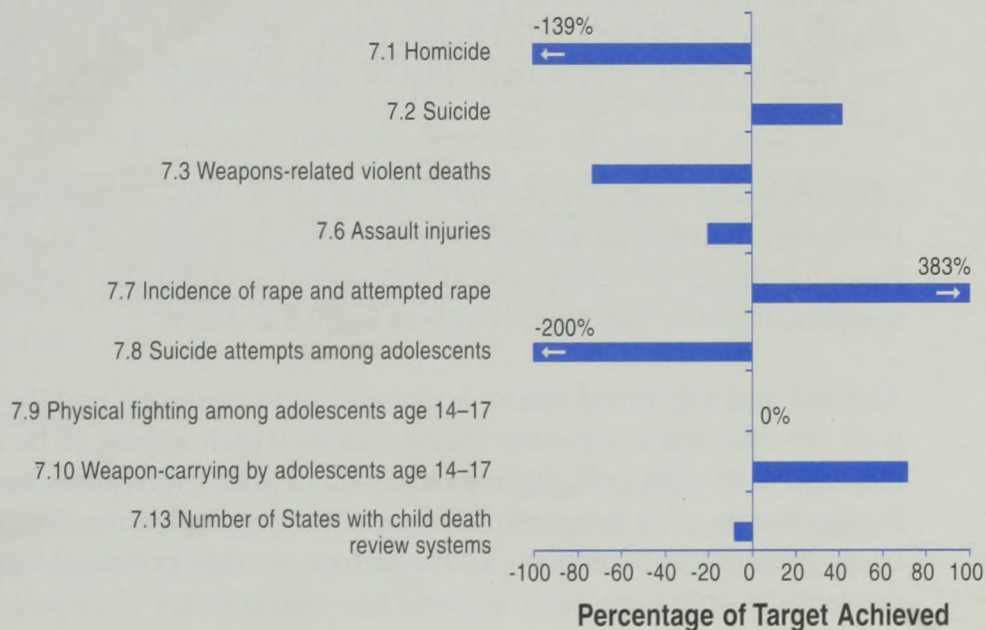
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7

Violent and Abusive Behavior

Status of Violent and Abusive Behavior Objectives



Tracking data for objectives 7.4, 7.5, 7.11, 7.12, and 7.14-7.18 are unavailable.

Lead Agency: *Centers for Disease Control and Prevention*

VIOLENT AND ABUSIVE BEHAVIOR

Few issues pose a greater challenge to public health and American society than violence. The United States ranks first among industrialized nations in violent death rates, with homicide and suicide claiming more than 50,000 lives each year. Annually there are an additional 2.2 million people injured by violent assaults. Several States and the District of Columbia report more deaths related to firearms than to motor vehicle crashes. The *Morbidity and Mortality Weekly Report* of January 28, 1994, compared trends and patterns of deaths resulting from firearm- and motor-related injuries in the United States from 1968–1991. If trends continue, the death rate from firearms will surpass that of motor vehicle crashes in the Nation by the year 2003.

Morbidity and mortality due to violence show some disturbing trends. Youth are increasingly involved as both perpetrators and victims of violence. Women are frequent targets of both physical and sexual assault often perpetrated by spouses, ex-spouses, intimate partners, or others known to them.

Alcohol and substance abuse, accessibility to firearms, and the violence associated with the drug trade are other major factors which appear to be contributing to the increase in violent and abusive behavior. Those individuals and families living in environments with the greatest erosion of social infrastructure are at high risk of being affected by violence. These factors provide potential keys to successful prevention strategies.

Based on its success with infectious diseases, reduction of smoking, and motor-vehicle injuries, the public health model holds promise in effectively addressing the complex problem of violence. This model uses the principles of epidemiology to focus on and examine the root causes and/or factors that contribute to violence. The public health model complements existing prevention efforts, provides a multidisciplinary scientific approach specifically directed toward identifying effective approaches to violence prevention, and emphasizes outcome-based evaluation of interventions.

Strategies for addressing violence-related objectives require the combined effort of the Public Health Service and State and local governments as well as many private organizations throughout the Nation. Among the strategies for addressing violence in communities at high risk are: promoting awareness of violence as a public health problem, taking more aggressive steps to counter the high rates of physical abuse and violence against women, offering alternative school and community-based activities for youth, and increasing collaboration and partnerships between State and local public health agencies with mental health and substance abuse programs.

There is a serious gap in knowledge and understanding of the causes and prevention of violent behavior. In addition to individual factors, familial, social, and economic (systemic) influences must be studied to determine their impact on violent behavior.

Review of Progress

Three of the 18 objectives are progressing toward the year 2000 targets. Suicides in the total population have remained stable for the past decade. However, the current concern is the increasing number of suicides among young males—both black and white. Rape and reported rape per 100,000 declined between 1986 and 1992. Weapon carrying by adolescents aged 14–17 decreased between 1991 and 1993. The Nation is moving away from the targets for homicides, firearm-related deaths, assault injuries, and suicide attempts by adolescents. The number of States with unexplained child death review systems has declined.

Homicides continue to be particularly widespread and an alarming problem (see State map). There has been a significant increase over baseline levels for homicides, with a 22 percent increase in the homicide rates among young men. The homicide rate for young black men exceeded that of young



white men in 1992 by as much as eight times. The target for black males aged 15–34 is 72.4 per 100,000. Unfortunately, there has been a dramatic increase from 90.5 per 100,000 in 1987 to 112.4 per 100,000 in 1989. The majority of this increase is attributable to firearm homicides which may be related to weapon carrying.

Baseline data for objectives 7.11 and 7.16 have been established. Three objectives, 7.12 (protocols for identifying, treating, and referring people to emergency departments), 7.14 (increase the number of States in which neglected or abused children receive evaluation and followup), and 7.17 (extend violence prevention programs to local communities) have no baseline data.

1995 Revisions

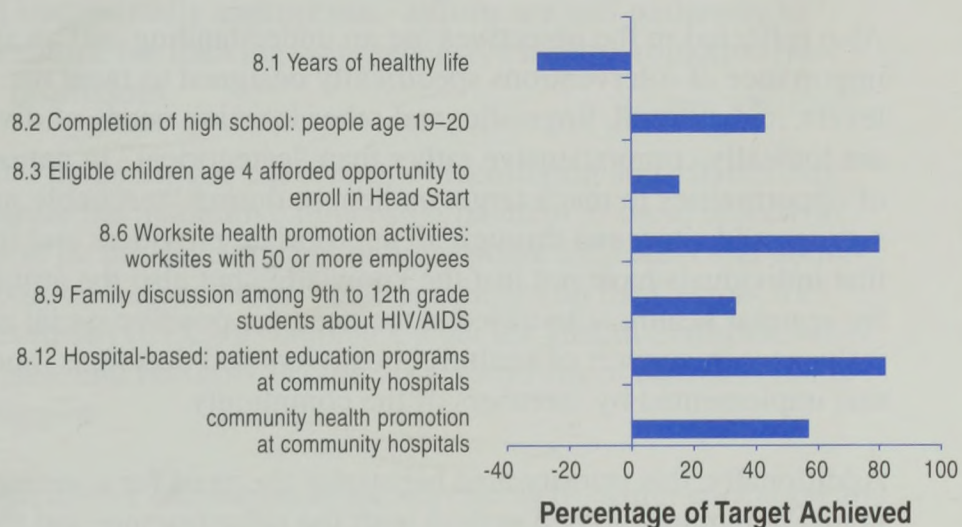
Added to this priority area is one new objective seeking the enactment of State laws that require the proper storage of firearms to minimize access and discharge by minors. This objective currently lacks a followup data source but is deemed extremely important to include because of the number of deaths and numerous injuries among unsupervised minors and youths with access to firearms.

Other changes in this priority area involve language revisions. In objective 7.3, the term “weapon” has been replaced by “firearm” because firearms are the major contributing factor to the recent increases in both interpersonal and self-directed violence, especially among young people. Handguns were used in 78 percent of all firearm crimes in 1992. In objective 7.16, the term “comprehensive school health education” replaced “quality school health.”

Special population targets have been added for blacks in objectives 7.3, firearm-related deaths; 7.9, physical fighting by adolescents; and 7.10, weapon carrying by adolescents. Female adolescents were added to objective 7.8 in recognition of their high rates of injurious suicide attempts. The special population targets for American Indians/Alaska Natives have been expanded to include all people in this racial category, not just those in Reservation States. An adjustment to the baseline and target in objective 7.1 for Hispanic homicides reflects revised 1990 census data. Revisions to the methodology in calculating the incidence of the types of maltreatment of children in objective 7.4 have resulted in changes in the year 2000 targets.

Educational and Community-Based Programs

Status of Educational and Community-Based Programs Objectives



Tracking data for objectives 8.4, 8.5, 8.7, 8.8, 8.10, 8.11, 8.13, and 8.14 are unavailable.

Lead Agencies: *Centers for Disease Control and Prevention*
Health Resources and Services Administration

EDUCATIONAL AND COMMUNITY-BASED PROGRAMS

This priority area focuses on population-based prevention initiatives, programs, and interventions as well as on “the how” of community health education and health promotion planning, design, and implementation efforts to achieve desired health status outcomes. The objectives in this priority area recognize that effective health education and community-based efforts must be developed through collaboration and must incorporate a series of planned, coordinated, and ongoing strategies and approaches to foster and reinforce behaviors conducive to health.

Also reflected in the objectives are an understanding and an appreciation of the importance of interventions specifically designed to meet the age, developmental levels, and cultural, linguistic, and other learning needs of diverse target audiences; are topically comprehensive rather than “categorical” in nature; take full advantage of opportunities to reach target audiences during “teachable moments” in a variety of settings and sites, and through all appropriate providers and intermediaries; ensure that individuals have not just the knowledge but also the attitudes and skills needed for optimal health; acknowledge the need for positive social and environmental influences in support of healthful behaviors and decisions; and are able to be planned and implemented by members of the community.

Additionally, this priority area highlights the need for a strong, cohesive, and integrated community-based system with the infrastructure and the capacity to carry out the essential services of public health. Such a system requires partnerships not only between public health, environmental health, and substance abuse and mental health agencies in the public sector, but also between the public sector, private health/medical care institutions, and voluntary organizations.

Review of Progress

The objectives in this priority area emphasize increases and improvements in health education and promotion programs for all major population groups, including racial and ethnic minorities, and in the major settings within which these populations can best be reached. Specific attention is paid to enhancing the positive roles that the family and the media can play in health education and health promotion efforts.

This priority area includes one health status objective related to increasing years of healthy life and one risk reduction objective aimed at increasing the high school completion rate (and reducing school dropout rates associated with social and health problems). The remaining services and protection objectives reflect an emphasis on increasing the numbers of educational and community-based programs; underscoring the need for preschool child development programs, comprehensive school health education, health promotion programs in postsecondary institutions, worksite health promotion programs (including activities for hourly workers), health promotion programs for older adults, family discussions of health issues, planned community health promotion programs, programs for racial and ethnic minorities, hospital-based patient education and community health promotion, partnerships between local

television networks and community organizations, and provision of essential services, as appropriate, by local health agencies.

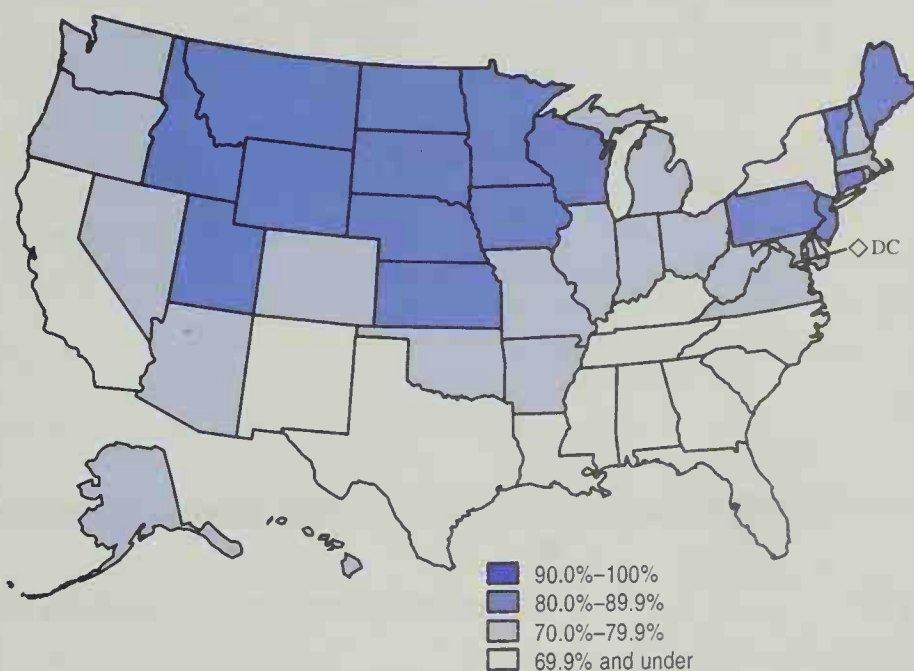
Data indicate progress toward the targets for objectives related to preschool child development programs, worksite health promotion activities, family discussion of health issues, and hospital-based patient education and community health promotion. Movement appears to be away from the target for years of healthy life. Progress related to the other objectives has been mixed. No data sources have been identified for objectives related to community health promotion programs that are broad-based, as well as culturally and linguistically appropriate. Efforts are still underway to identify a followup data source for tracking comprehensive health promotion programs in postsecondary institutions.

Data issues may be rooted in the unique challenges of identifying and establishing meaningful ways to measure the qualitative dimension inherent in these objectives. The main task continues to be the development of appropriate indicators and definitions to measure and report on interventions. Collaboration with the Centers for Disease Control and Prevention (CDC)'s National Center for Health Statistics, other Federal agencies, the States, and HEALTHY PEOPLE 2000 Consortium members holds the most promise for progress.

The importance of the qualitative dimension and components of health education and community-based health programs along with multiple and strong partnerships is underscored by the kinds of health promotion programs and initiatives being fostered at the national, State, and community levels. For example, the "Healthy Cities, Healthy Communities" project is a non-Federal, national initiative aimed at improving the well-being and quality of life of people in communities through "inter-connectedness" among many different players, supportive local structures and policies, and approaches tailored to the unique needs, resources, cultures, and infrastructures within each community.

The Empowerment Zone/Enterprise Community (EZ/EC) Program and the GOALS

Objective 8.2: Increase the high school completion rate to at least 90 percent



Source: Department of Education, National Center for Education Statistics, 1992

2000: Educate America Act are examples of Federal initiatives that acknowledge the need for ongoing and comprehensive efforts and partnerships to effect change in communities. The EZ/EC initiative encourages localities—through such means as enhanced funding and tax incentives for business and job development—to undertake community-based strategic planning, involving individuals and organizations focusing on a broad range of health, human development, and other needs. The GOALS 2000: Educate America Act, enacted in March 1994, requires collaboration between the Department of Education and the Department of Health and Human Services to meet national education goals related to school readiness, school completion, school achievement, teacher education and professional development, parental participation, and safe and drug-free schools. The targets for the objectives in this priority area related to completion of high school and preschool child development programs are consistent with the national education goals.

Efforts at the State level to reform the delivery of health care have encouraged the formation of partnerships with local, State, and Federal agencies; alcohol and drug abuse, mental health, and environmental health agencies; professional public health organizations; academic health institutions; and others to strengthen the public health system and infrastructure throughout the country. Consensus was reached in the fall of 1994 around the use of common terminology to describe the vision, mission, and essential services of public health. Further collaborative action is critical to supporting and effecting successful educational and community-based programs to improve the health of communities.

1995 Revisions

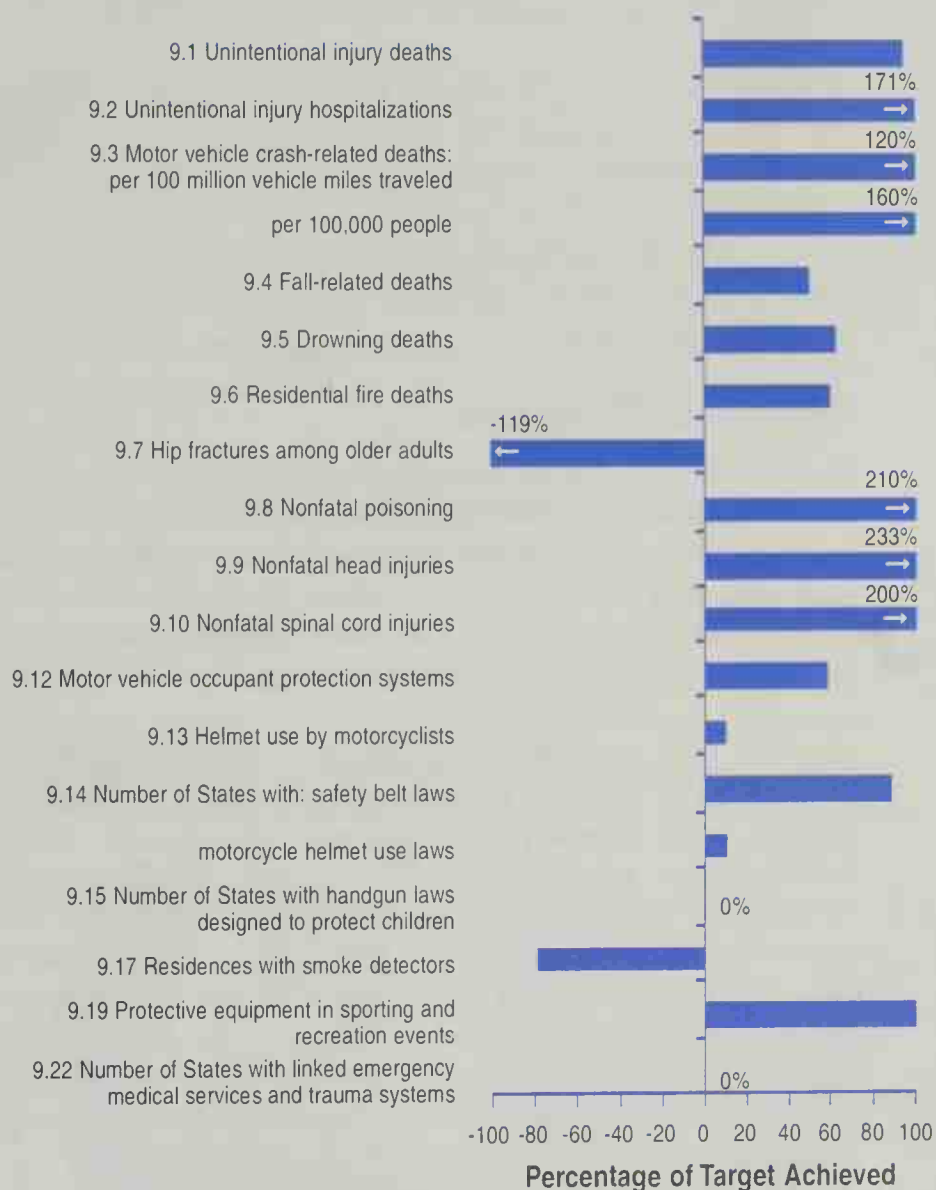
Two changes have been made in this priority area. In objective 8.2, the term high school graduation rate was replaced with high school completion rate to include students who complete high school with alternative credentials. The objective now is aligned with the measures used by the Department of Education to track the national education goals.

The term “quality school health education” was replaced with comprehensive school health education, a term more widely recognized in the professional literature, and by public health, health education, and school health professionals. Comprehensive school health education is measured by surveillance systems at CDC.

9

Unintentional Injuries

Status of Unintentional Injuries Objectives



Tracking data for objectives 9.11, 9.16, 9.18, 9.20, and 9.21 are unavailable.

Lead Agency: *Centers for Disease Control and Prevention*

UNINTENTIONAL INJURIES

In 1992 injuries cost \$399 billion in the United States. Included in this figure are lost wages, medical expenses, motor vehicle damage, fire losses, and administrative costs of police, lawyers, and insurers. The National Safety Council estimates that motor vehicle crashes account for 39 percent of these costs; work-related injuries, 29 percent; home injuries, 21 percent; the remaining 11 percent occur at various sites. The opportunities are at hand to prevent the more than 86,000 injury deaths and the suffering that accompanies the more than 145,000 injuries that occur each year.

Most injury research focuses on fatalities because of the availability of data. However, data are needed on the causes and outcomes of both fatal and nonfatal injuries in order to present a complete picture of the extent of the injury problem in the United States. There is inadequate surveillance on injury morbidity, disability, and costs to identify injury risk factors and to evaluate injury prevention programs. Linkage of databases is one promising method of using existing data for research, planning, and evaluation.

Review of Progress

The year 2000 target for reducing unintentional injury deaths was reached in 1993 with 29.2 deaths per 100,000 population. Now the challenge is maintaining that accomplishment. Decreases in unintentional injury hospitalizations per 100,000 have exceeded the target. In part these successes are due to the reductions that have occurred in motor vehicle crash-related deaths and the declining rates of injuries from falls, drowning, fires, and poisonings.

Between 1987 and 1993, there was an overall decline of 13.5 percent in the number of motor vehicle traffic fatalities. The decrease for young people has been even greater—with the rate for children aged 14 and under declining by 15.9 percent and that for people aged 15–24 by 27.2 percent. The growth in vehicle miles traveled continues to outpace the increase in fatalities. Between 1966 and 1993 there was some year-to-year fluctuation in the motor vehicle fatality rate per 100,000 population, but the overall trend has been downward, with a reduction in rate from 19.1 in 1987 to 15.6 in 1993. Part of this success can be attributed to increased use of motor vehicle occupant protection systems—up 56 percent from the baseline. By the end of 1994, 48 States, the District of Columbia, and Puerto Rico had safety belt use laws, and all States had some form of child safety seat law.

Only Hawaii has reached the year 2000 target for 85 percent use of safety belts in 1993 based on self-reports in the Behavioral Risk Factor Surveillance System. The number of States with motorcycle helmet use laws totaled 25 in 1994. There has been some slight improvement in the use of helmets by motorcyclists—from 60 to 62 percent; but the use of helmets by bicyclists—estimated at 5–10 percent—shows little change from the 8 percent baseline.

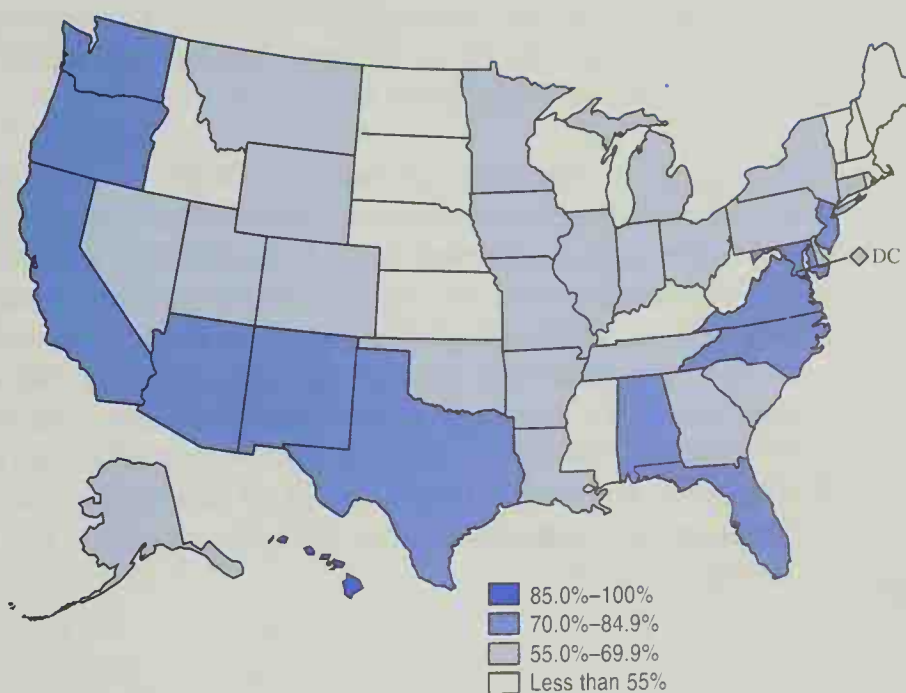
A number of objectives are proceeding toward the target. Fall-related deaths (age-adjusted) reached 2.5 per 100,000 population in 1992. Drowning deaths (age-adjusted) declined to 1.6 per 100,000 population in 1992. Residential fire deaths (age-adjusted) were 1.4 per 100,000 population in 1992. Nonfatal poisonings decreased to 66 per 100,000 population in 1993 and have exceeded the year 2000 target. Similarly, nonfatal head injuries declined to 90 per 100,000 population in 1993, lower than the year 2000 target. Nonfatal spinal cord injuries declined to 4.7 per 100,000 population in 1993, passing the year 2000 target.

Hip fractures among older adults have increased and are moving away from the year 2000 target. In 1993 the rate of hip fractures had increased to 841 per 100,000 people over the age 65. Primary care providers can help prevent injuries by routinely inquiring and counseling patients about their activities at home and in automobiles. Yet a 1992 Primary Care Provider Survey showed that the percent of clinicians routinely inquiring or counseling about these matters was generally low. Among nurse practitioners 15 percent reported that they routinely inquired and 17 percent routinely advised older adults (65 years and older) on the prevention of falls at home; family physicians, 7 percent and 15 percent respectively; and internists, 10 percent and 17 percent.

Among pediatricians, 45 percent reported that they routinely inquire about safety belt/child seat use, while 58 percent reported that they routinely advised patients about safety belts/child seats. The findings for other providers were: nurse practitioners, 29 percent and 32 percent; pediatricians and family physicians, 16 percent and 29 percent respectively; and obstetricians/ gynecologists, 6 percent and 18 percent.

The number of States with handgun design laws to protect children remains at zero. The number of residences with at least one functional smoke detector on each habitable floor appears to have declined between 1989 and 1993. However, comparability of baseline and current data suggest that such conclusions be drawn with some degree of caution. No national data currently are available to track the objectives on the incidence of secondary conditions associated

Objective 9.12: Increase the use of occupant protection systems to at least 85 percent of motor vehicle occupants



Source: CDC, BRFSS, (self-reported safety belt use only), 1992

with head and spinal cord injuries; injury prevention instruction in schools; fire suppression sprinkler installation; or the number of States with design standards for roadway safety. The language of some of these objectives was modified to make them more trackable.

1995 Revisions

Three new objectives have been added to this priority area. One seeks to increase the number of States that require cyclists to use bicycle helmets. As of 1994, nine States required helmets for bicycle riders. The second is a new objective in the Violence and Abusive Behavior priority area being added as a shared objective in Unintentional Injuries. This new objective seeks to enact laws in 50 States requiring that firearms be properly stored to minimize access and the likelihood of discharge by minors. No States had such laws in place in 1994. The third objective added seeks the requirement of graduated driver licensing systems (learner's permit, intermediate license, and full license) in all 50 States. In 1994, 26 States had graduated licensing systems.

Special population targets have been added to several objectives: Mexican-American males to objective 9.1 to reduce high unintentional injury death rates; black males to objective 9.2 to reduce rates of hospitalization for nonfatal unintentional injuries; Mexican Americans to objective 9.3 to reduce high rates of motor vehicle crash deaths; American Indians/Alaska Natives to reduce deaths from falls and fall-related injuries, from drownings, and fires; and American Indians/Alaska Natives and Puerto Ricans to objective 9.6 to reduce residential fire deaths.

The year 2000 targets for objective 9.3 and the special population targets for children and youth were revised to be more challenging. The baseline and target revisions for American Indians/Alaska Natives have been expanded to include all American Indians/Alaska Natives, not just those living in Reservation States. Objective 4.1, to reduce fatal motor vehicle crash deaths that involve alcohol, is being added as a shared objective to this priority area.

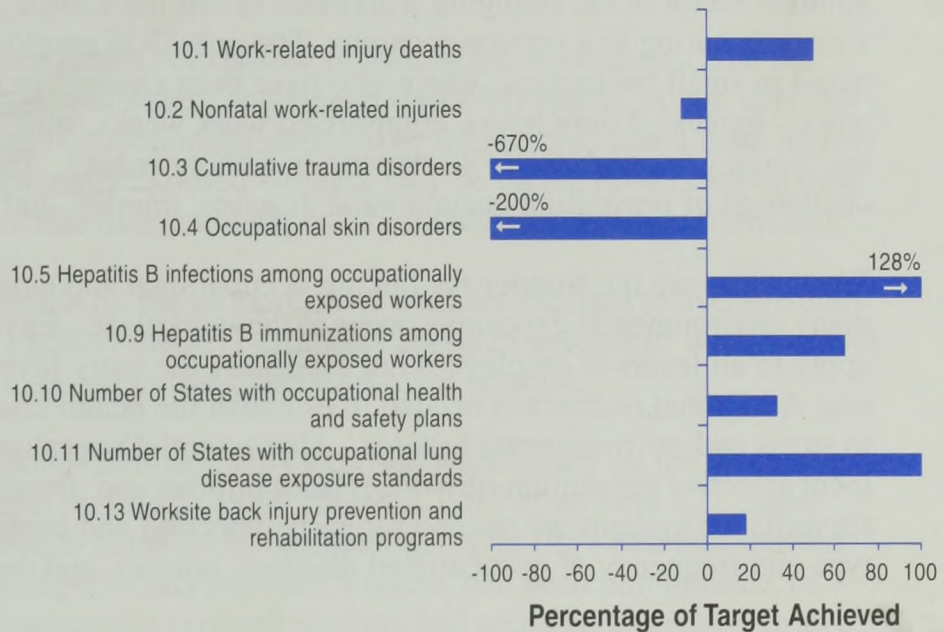
The language in objective 9.11 was amended to be more focused. Similarly, objective 9.12 puts specific attention on safety belt and appropriate child safety restraint use. Further action is needed at the Federal, State, and local levels to increase use rates of both safety belts and child restraint systems. Because the 1993 Federal Motor Vehicle Safety Standard requires inflatable restraints (air bags) in the front seat driver and passenger positions of new passenger cars and light trucks sold in the United States, the language on occupant protection systems related to inflatable safety restraints has been dropped. By the year 2000, the phased-in requirement of this standard will cover 100 percent of all new light vehicles. As older vehicles are replaced by new vehicles, in time, all light vehicles in use will be equipped with inflatable restraints.

A new special population target has been established for use of child restraint systems among children aged 4 and younger involved in potentially fatal crashes. The 1988 baseline for this new subobjective shows that less than half of the children in this age group (48 percent) were in child safety seats.

Language changes were made to objective 9.14, adding the word universal to modify helmet, and covering adults as well as minors. Head injury due to motorcycle crashes is a problem for all people regardless of age or seating position. Laws governing all motorcycle occupants significantly increase helmet use and are more easily enforced than age-specific laws. The National Highway Traffic Safety Administration's latest survey (November 1991) indicated that helmet use was nearly 100 percent at sites with helmet use laws governing all motorcycle riders compared with only 34–54 percent at sites with no helmet use laws or laws limited to minors. Data on crashes in States where only minors are required to wear helmets show that fewer than 40 percent of the fatally injured minors were wearing helmets.

In objective 9.20, the target has been revised from 30 to 50 States since the Federal Highway Administration will revise the Manual on Uniform Traffic Control Devices by 1997. The revisions will address the need to improve visual stimuli and safety for older drivers and pedestrians. Minimum levels will be established for retro-reflectivity of highway signs and pavement markings, thereby improving the safety of the roadways.

Status of Occupational Safety and Health Objectives



Tracking data for objectives 10.6-10.8, 10.12, 10.14, and 10.15 are unavailable.

Lead Agency: *Centers for Disease Control and Prevention*

OCCUPATIONAL SAFETY AND HEALTH

The American workplace is changing and becoming more diverse. Women now comprise 46 percent of the labor force and are projected to be 47 percent by the year 2000. Minorities, 23 percent of the workforce in 1994, will be 27 percent by the year 2000. The median age of the American worker, 37.9 years in 1992, will be 39.2 years by 2000.

Another factor in the changing workplace is that the United States has evolved from a manufacturing to a service economy. The growth in employment now is concentrated in small businesses. There also have been changes in the organization of work—expanded duty hours, compressed work weeks, shift work where the employees' hours vary, and longer work periods without breaks. These changes increase the challenges of preventing occupational diseases, injuries, and deaths.

Workplaces are the frontier for linking occupational and environmental health since many environmental exposures occur at the workplace. Environmental justice issues apply to all levels of employees but especially the entry-level and lower paid workers. Additional research is needed to establish the health effects of exposures at work to stress and environmental hazards. Also essential is evaluation research to document effective prevention of work-related injuries and diseases. Improved data from surveillance systems are needed for early detection and continuous assessment of the type and frequency of occupational diseases, injuries, and deaths.

Review of Progress

While work-related injury deaths have been reduced from 6 to 5 per 100,000 workers in 1993, nonfatal injuries at work have fluctuated between 8.3 in 1988 and 7.9 per 100 workers in 1993. However, among certain occupational categories the death rates are more than double and continue to require specific interventions. For construction workers, for example, work-related injury deaths have fallen from a 1983–1987 baseline of 25 per 100,000 workers to 14 in 1993. Work-related injuries that resulted in medical treatment, lost time from work, or restricted work activity declined from a 1983–1987 baseline of 14.9 per 100,000 construction workers to 12.0 in 1993. Transportation workers' death rates have fallen from 15.2 to 13 per 100 workers over this same time period, yet the injury rates have increased from 8.3 to 9.1 per 100.

Cumulative trauma disorders are increasing. Increases in reported cumulative trauma disorders may be due to heightened awareness and better reporting as well as to changes in work design such as increased automation and job specialization, both of which increase the amount of repetition required by the worker. The incidence per 100,000 workers has more than tripled from 100 to 368 between 1987 and 1992. Among the special target populations in this objective, manufacturing workers experienced cumulative trauma disorders at a rate of 355 per 100,000 workers in 1987, compared with 1,241 in 1992. Similarly, the rate for meat production work-

ers' is increasing—3,920 per 100,000 in 1987, compared with 8,475 per 100,000 in 1992. These trends make the year 2000 targets seem quite elusive.

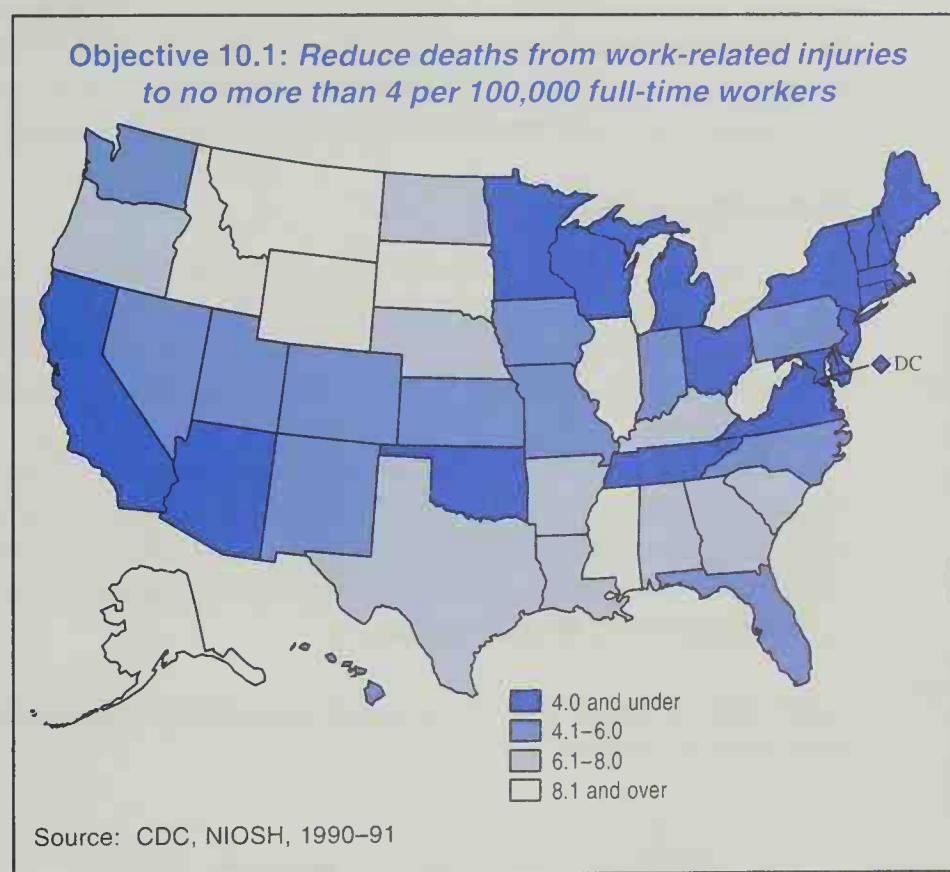
Occupational skin disorders are also on the rise. From a 1983–87 baseline of 64 per 100,000 full-time workers, the 1992 rate increased to 82 per 100,000 workers. This increase may be due to increased awareness by both workers and health care professionals, increased reporting of occupational skin disorders, or possible shortcomings in prevention.

Another threat to employee health is exposure to lead in the workplace. The National Institute for Occupational Safety and Health (NIOSH) estimates that approximately 30,000 workers are occupationally exposed to lead (extrapolated from reports from 22 States). Occupationally exposed workers may be taking home lead on their clothes, person, or automobile that could expose their children to this contaminant.

No national data are available on the proportion of workers exposed to average daily noise levels that exceed 85dBA. NIOSH estimates about 25 percent of workers in all employment sectors are exposed to this dangerous level of noise.

Hepatitis B infections among occupationally exposed workers are on the decline. The 1987 baseline has been revised to 3,090 cases; in 1993 there were 727 cases. This trend parallels the rise in hepatitis B vaccinations. The 1989 baseline showed that only 37 percent of occupationally exposed workers had been immunized. In 1994, 71 percent of occupationally exposed workers had received protection from a vaccination for hepatitis B.

Motor vehicle crashes are the leading cause of fatal injury death in the workplace. A HEALTHY PEOPLE 2000 objective tracks the extent to which worksites with 50 or more employees mandate employee use of occupant protection systems such as safety belts during all work-related motor vehicle travel. A survey of worksites showed that in 1992, 82.4 percent of worksites with 50 or more employees had such mandates. This same survey also



established the baseline for the proportion of worksites with 50 or more employees that have implemented worker health and safety programs. In 1992, 63.8 percent of employers reported having such programs in place.

Research is needed to identify aspects of back injury programs that are effective in preventing injury. In 1985, 28.6 percent of worksites with 50 or more employees had such programs; in 1992, 32.5 percent actively were working to prevent back injuries.

Another risk reduction objective seeks to increase to 50 the number of States that implement occupational safety and health plans for the identification, management, and prevention of work-related disease and injuries within the States. The 1989 baseline showed that 10 States had such plans; in 1992, 32 States had these plans. Because Federal standards have been established for occupational exposure to airborne asbestos fibers, cotton dust, coal mine dust, and silica dust, objective 10.11 has been achieved.

While much of the focus of occupational safety has been on large employers, there is a need to address small businesses. In 1991, 26 States were providing consultation and assistance to small businesses to implement safety and health programs for their employees.

Primary care providers can play an important role by routinely eliciting information from patients on their occupational health exposures. However, a 1992 provider survey showed that the percent of clinicians routinely inquiring or counseling about work-related health risks was very low. Among family physicians and pediatricians, 7 percent reported that they routinely inquire about work-related risks, while 8 percent reported that they routinely counsel about work-related risks. For other providers the results were: obstetricians/gynecologists, 6 percent and 10 percent, and nurse practitioners, 14 percent and 10 percent. More attention is needed in training primary care providers in understanding the impact of occupation on health.

1995 Revisions

Two new objectives have been added to this priority area. One seeks to reduce the rate of homicides occurring in the workplace, the third leading cause of fatal injury for workers and the leading cause of injury death for women in the workplace. This problem of violent behavior must be addressed to ensure the safety of U.S. workers.

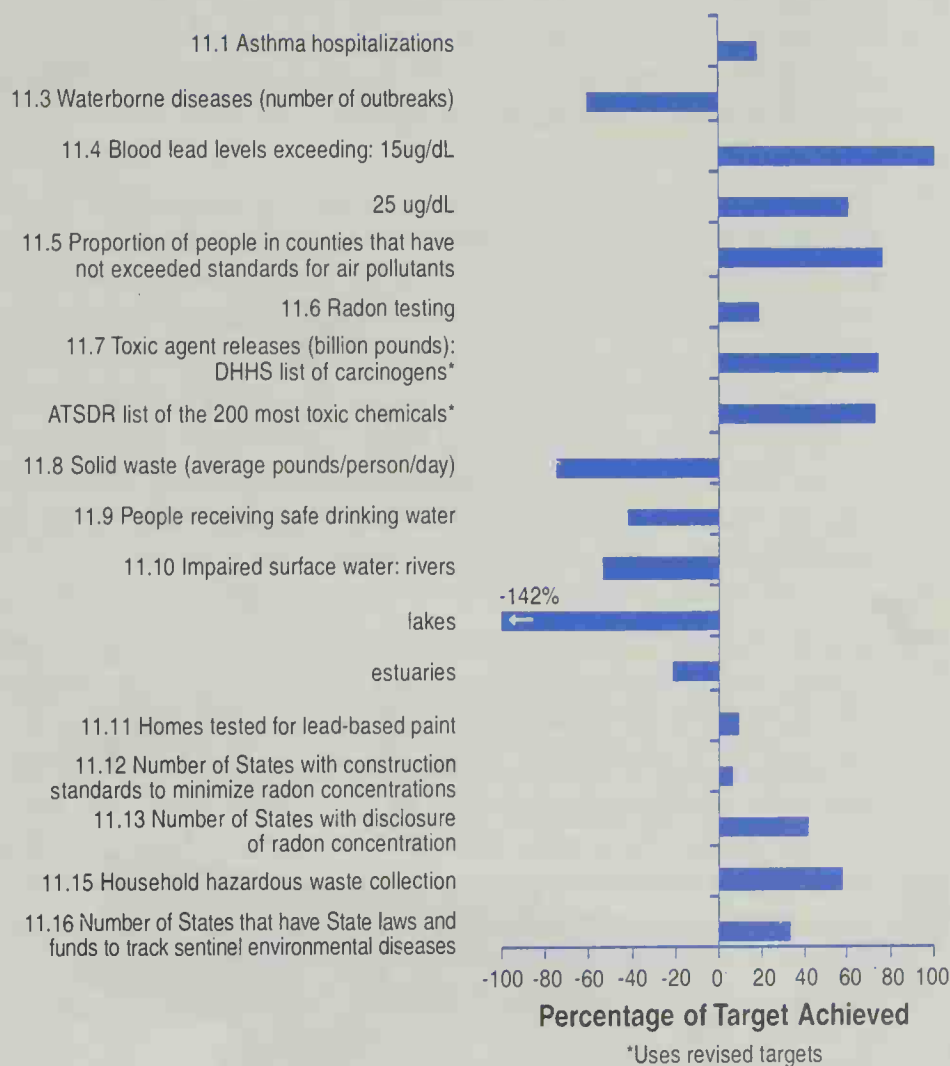
The second new objective complements objective 10.11 and seeks to reduce the age-adjusted mortality for four major preventable occupational lung diseases (byssinosis, asbestosis, coal workers' pneumoconiosis, and silicosis) to 7.7 per 100,000. This reduction is possible to achieve if exposures are limited and certain high-risk occupations are targeted for interventions.

Adolescent workers have been added as a special population target for reducing work-related injuries.

The baseline in objective 10.5 for hepatitis B was revised; the target has been proportionately adjusted. The target for objective 10.6 at 95 percent has been made more challenging because the baseline showed that 82 percent of worksites with 50 or more employees required use of occupant protection systems.

Two existing objectives from other priority areas are being added to the Occupational Safety and Health priority area. They are objectives 3.11, worksite smoking policies, and 3.12, clean indoor air laws from the Tobacco priority area.

Status of Environmental Health Objectives



Tracking data for objectives 11.2 and 11.14 are unavailable.

Lead Agencies: *National Institutes of Health*

Centers for Disease Control and Prevention

ENVIRONMENTAL HEALTH

In its ongoing efforts in disease prevention, the Public Health Service (PHS) has long recognized the critical importance of environmental risks as underlying factors that can contribute to the disease process. Among the numerous diseases and dysfunctions that have a known or suspected environmental component are cancer, reproductive disorders such as infertility and low birthweight, neurological and immune system impairments, and respiratory conditions such as asthma. Exposure to environmental hazards can be through air, food, or water and covers a broad range of factors such as pesticides, toxic chemicals, and radiation. In large part the environmental component of a particular disease or health outcome is frequently the result of repeated and cumulative exposures.

Breast cancer, the second leading cause of cancer death in women, is a critical public health problem that results from the complex interaction of genetics, hormonal, and possibly environmental factors. PHS has supported research to examine potential environmental and other risks, including the Long Island Breast Cancer Study Project. Among the factors being evaluated in study participants are exposures to contaminated drinking water, sources of indoor and ambient air pollution, electromagnetic fields, pesticides and other toxic chemicals, hazardous and municipal waste, and lifestyle factors such as dietary patterns. An increase in the knowledge base of the many factors contributing to breast cancer will support development of population-based prevention strategies.

In carrying out its responsibility to monitor health impacts related to environmental exposures, public health has shown increasing concern about disproportionate and adverse effects on low-income and minority populations. Programs have been undertaken in response to such concerns and include the collection of data to monitor particular health outcomes such as blood lead levels and the establishment of registries for particular events, such as cancer sites. Use of such information has stimulated policy to ensure increased consideration of human health effects related to disproportionate environmental exposures among these populations, more generally known as environmental justice. A 1994 Executive Order requires Federal agencies to develop a strategic plan to address environmental justice issues in their programs.

Increasingly, there has been recognition of the need for better coordination and integration across all levels for the most effective response to environmental health concerns. Among the examples of this type of process are the U.S. Environmental Protection Agency's (EPA) development of national environmental goals. EPA used the background and experience of PHS in developing national goals, including public participation, quantitative orientation, and a means to track progress. Goals now are set for clean air, clean water, safe drinking water, safe food, safe workplaces, prevention of toxic releases, and better waste management. Successful collaboration also is ongoing among health and environmental officials in Federal, State, and local settings. One important case example occurred in the Milwaukee area where approximately 400,000 residents were affected by a contaminated water supply.

A prompt and coordinated public health response resulted in identification of the microorganism involved and led to successful restoration of the city's clean drinking water supply.

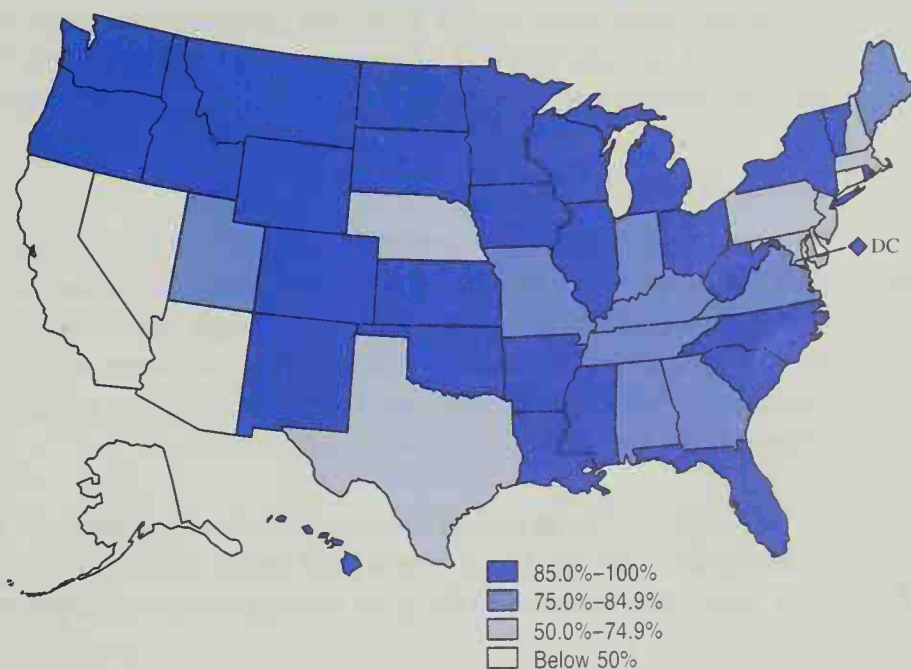
Review of Progress

In many western countries, including the United States, the prevalence of asthma morbidity and mortality has increased over the past decade. Asthma disproportionately affects children, women, minorities, and people who live in urban areas. Although every asthma death should be preventable, this disease resulted in 183 hospitalizations per 100,000 population and 4,964 deaths in 1992. There is a continuing need for research to determine the underlying etiology of asthma in order to improve prevention and treatment.

Substantial progress has been made in reducing blood lead levels, particularly among children. As reported in the National Health and Nutrition Examination Survey, the number of children with blood lead levels above 25 µg/dL has been reduced from 234,000 in 1984 to 93,000 in 1989; for lead levels above 15 µg/dL these numbers are 3 million and 503,000, respectively. Several factors have contributed to these improvements. First, the amount of lead used in gasoline declined by 99.8 percent from 1976 to 1990. Second, the percentage of U.S. manufactured food and soft-drink cans containing lead solder declined from 47 percent in 1980 to 0.9 percent in 1990. Other factors include the ban on leaded paint for residential use, promulgation of a standard for lead exposure in industry, the ban on lead-containing solder in household plumbing, the implementation of lead poisoning prevention programs by numerous States and cities, lead screening laws in 16 States, and lead paint abatement programs in some jurisdictions.

Continued improvements have been seen on other fronts in environmental health. Implementation of the Clean Air Act of 1990 has helped to increase the proportion of people living in counties that meet EPA standards for air pollution from 49.7 percent in 1988 to 76.5

Objective 11.5: Reduce human exposure to criteria air pollutants as measured by an increase to at least 85 percent in the proportion of people who live in counties that have not exceeded EPA standards



Source: EPA, 1993

percent in 1993. Recycling efforts also have increased across the Nation. In 1991, 26 percent of the population was served by a curbside recycling program, according to the *Biocycle Journal of Composting and Recycling*. By 1993 the number had increased to 39 percent.

There has been a decrease in toxic agents released into the air, water, or soil. Between 1988 and 1993, the volume of HHS-listed carcinogens has decreased from an estimated 0.36 to 0.19 billion pounds. During this same period, the volume of 200 most toxic substances listed by the Agency for Toxic Substances and Disease Registry has decreased from 1.93 to 1.23 billion pounds. The year 2000 targets have been achieved.

Slight progress toward the year 2000 targets has been made for objectives related to reducing exposure to radon. The proportion of people who report their homes have been tested for radon has increased from less than 5 percent in 1989 to 11.4 percent in 1993. As of 1993, only three States had adopted construction standards and techniques to minimize radon levels. As of 1992, 13 States required disclosure of radon concentrations in conjunction with the sale of property. This relatively slow rate of progress may be related to consumers' lack of knowledge about radon and to public uncertainty about the extent of health risk that radon poses.

There is an apparent increase in the proportion of rivers, lakes and estuaries that are impaired; however, the data reported are on "assessed waters" and do not represent all surface waters. The locations tested may vary each year and preclude interpretation of the data as trends. Further, several States adopted stricter standards since the 1988 baselines were established, producing an apparent increase in impaired waters.

The number of waterborne disease outbreaks from infectious agents and chemical poisoning increased from 16 in 1988 to 19 in 1992. The percentage of the population whose drinking water meets EPA safe drinking standards declined from 73 percent in 1988 to 68 percent in 1993. Strengthened collaborations with EPA and State health officials should help to ensure safe drinking water availability.

1995 Revisions

Women of all races suffer greater asthma mortality and morbidity than men. Women also are more likely than men to be hospitalized for asthma problems and have a greater number of physician visits. Although the reasons for these gender differences are not clearly understood, a subobjective has been added which seeks to reduce asthma morbidity in women and focus attention on research and prevention of asthma with respect to women's health needs.

In July 1994, CDC released the results from the National Health and Nutrition Examination Survey III of blood lead levels (BLLs) in the U.S. population. These data show that the year 2000 goal related to the numbers of children in the United

States with BLLs above 15 µg/dL had already been achieved. The new goals take into account this recent data and have been made more challenging.

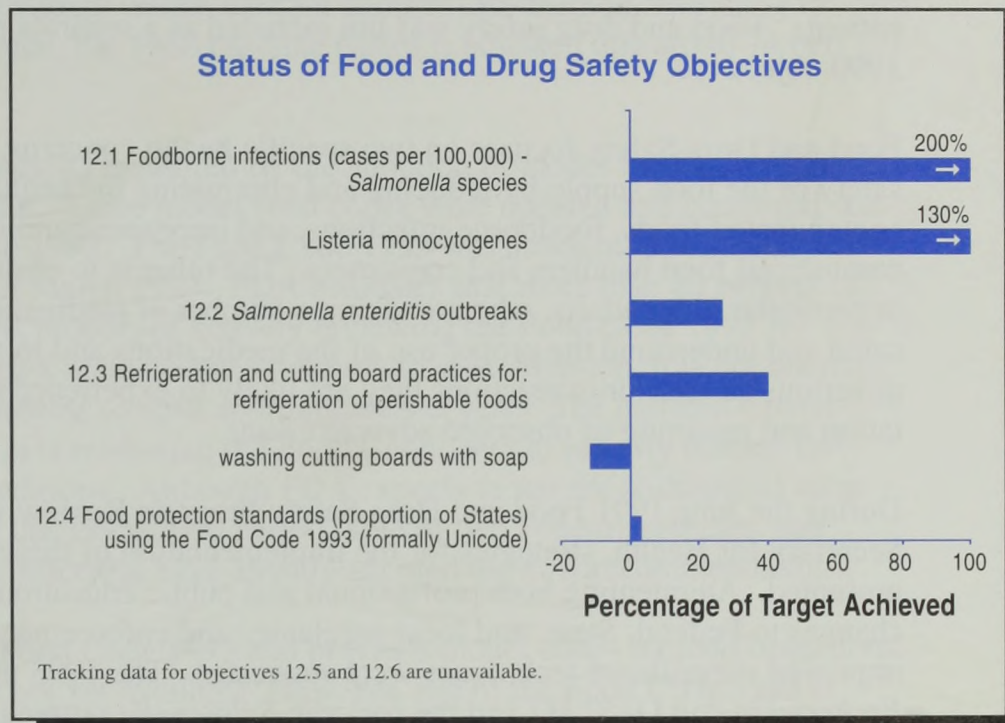
Language revisions have been made to update and further clarify several environmental health objectives. Exposure to solid waste contamination now will be tracked both before and after recovery to take into account the impact of recycling and composting on reducing the levels of municipal solid waste. This refinement will help demonstrate the progress of national recycling activities. Modifications also have been made to objective 11.10, which now will track potential human health risks from surface water by the percent of rivers, lakes, and estuaries supporting consumable fish and recreational activities. This revision reflects EPA data collection and provides greater insight into the impact of surface water contamination. A third language revision relates to monitoring recycling programs. Recycling now will be tracked for curbside programs on the basis of population served (rather than by county). A new focus on household hazardous waste collection has been added. Both changes are in line with EPA policy whereby curbside recycling and household hazardous waste collection are separate. The target for objective 11.8 has been revised to be consistent with EPA data and goals.

Objective 3.8, which seeks to reduce children's exposure to tobacco smoke at home has been added as a shared objective in this priority area.

The targets for objective 11.7, toxic agent releases, have been achieved. Therefore the targets have been revised to be more challenging.

12

Food and Drug Safety



Lead Agency: *Food and Drug Administration*

FOOD AND DRUG SAFETY

Food and Drug Safety was designated as a priority area for the year 2000 in recognition of the importance that food and drug safety plays in reducing the risks to public health associated with contaminated foods, foodborne pathogens, drug interactions, and noncompliance with drug regimens established by primary care providers for patients. Food and drug safety was not included as a separate priority area in the 1990 objectives.

Food and Drug Safety focuses on two specific health concerns. One is to ensure the safety of the food supply by reducing and eliminating the health risks posed by contaminated foods, foodborne infections, and improper handling of foods both by commercial food handlers and consumers. The other is to ensure that the public and in particular older adults, who are taking a number of medications, are better educated and understand the proper use of the medications and to reduce the incidence of serious adverse drug reactions they are likely to experience by effective documentation and reporting of observed adverse events.

During the June 1991 Food and Drug Safety Progress Review with the Assistant Secretary for Health, strategies for the implementation of these objectives were presented. Augmenting both professional and public educational efforts, appropriate changes to Federal, State, and local regulatory and enforcement initiatives, and improved surveillance techniques were suggested. The 1993 multi-State outbreak of *Escherichia coli* O157:H7 and the periodic *Salmonella* outbreaks illustrate the difficulties of controlling foodborne illness.

Review of Progress

Data demonstrate that progress has been made in the reduction of *Salmonella enteritidis* outbreaks from 77 during 1989 to 63 documented in 1993. Some of this progress may be attributed to recently implemented 1990 regulations that are focused on the reduction of salmonellosis from infected chickens and eggs together with focused consumer and education programs. In 1992, the majority of States reported the rate of *Salmonella* infections was below the 16 per 100,000 people targeted in HEALTHY PEOPLE 2000 Objective 12.1. Despite that fact, 12 States and the District of Columbia still exceeded the target. (See State map.)

National data that are specific for tracking infections caused by *Campylobacter jejuni* and *Escherichia coli* O157:H7 are not currently available. This is in part because the reporting systems for these foodborne pathogens are not uniform among the States, not available in a timely manner, and may be underreported.

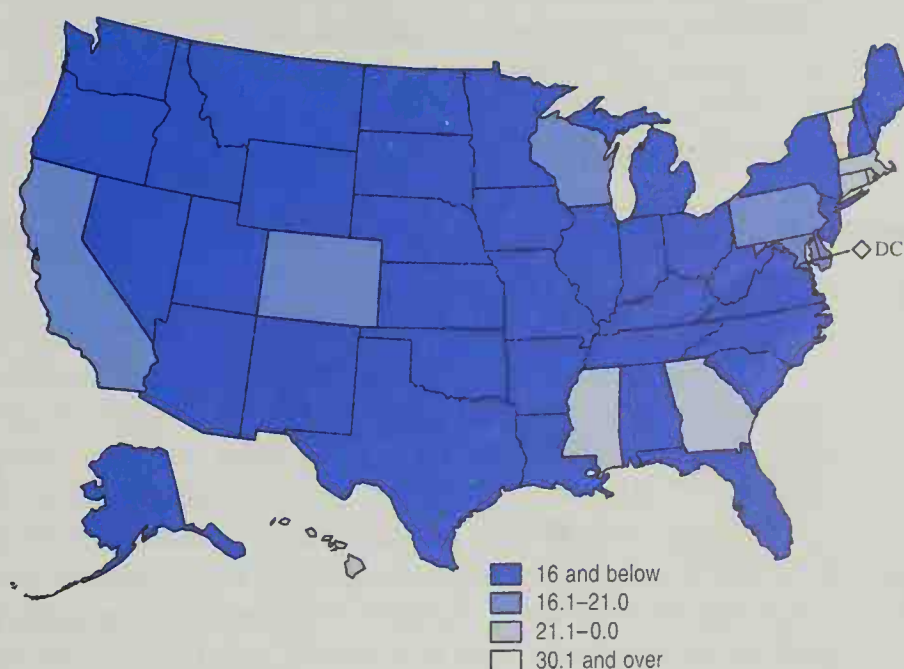
The 1992–1993 Food and Drug Administration Food Safety Survey found increased sanitation in household food handling practices. The practice of refrigerating perishable foods increased in use from 70 percent of households in 1988 to 72 percent in 1992–1993. The practice of washing cutting boards with soap showed little change, going from 66 percent in 1988 to 65 percent in 1992–1993. The 1988 data for

washing cutting boards with soap do not include other sanitation practices such as washing with bleach or the use of a different cutting board. The 1988 figure that includes these options is 70 percent and the 1992–1993 data showed 68 percent. Data were not collected in 1992–1993 on household utensil washing practices. The 1988 baseline figure of 55 percent represents the percentage of households found to be washing utensils with soap. When data for another safe method, switching to another knife, are included, the 1988 baseline figure is adjusted upward to 74 percent.

Food protection standards, as measured by the adoption of model food codes, are tracked in Objective 12.4. Three model food codes were updated and combined into one code during 1990 to 1993. The Food Code 1993 was announced in January 1994 and became available in March 1994. FDA estimates that more than 80 percent of the States are now in the process of actively reviewing the Food Code 1993 for possible adoption. Once a State makes a decision to seek adoption, it is not uncommon for the adoption process to span approximately 2 years. The national Conference for Food Protection is reviewing the Food Code 1993 to identify needed improvements for future editions. Although FDA expects to see the widespread adoption of the code during the 1995–2000 period, at least two Federal agencies, one State, and two local jurisdictions have already adopted the new recommendations.

Data on the use of the Food Code 1993 and previous model codes by food operations serving institutions are not yet available. However, use of the Food Code 1993 is being encouraged through active promotion by FDA and other agencies. FDA has produced food safety videos for nursing homes jointly with the Health Care Financing Administration (HCFA) and the Centers for Disease Control and Prevention (CDC). FDA and HCFA are cooperating in training health surveyors (nursing home inspectors) and providing information concerning foodborne illness and the Food Code 1993. FDA also participated with USDA in three video teleconferences to State and local officials to promote the Food Code 1993.

Objective 12.1: Reduce infections caused by key foodborne pathogens (*Salmonella species*) to an incidence of no more than 16 per 100,000 people



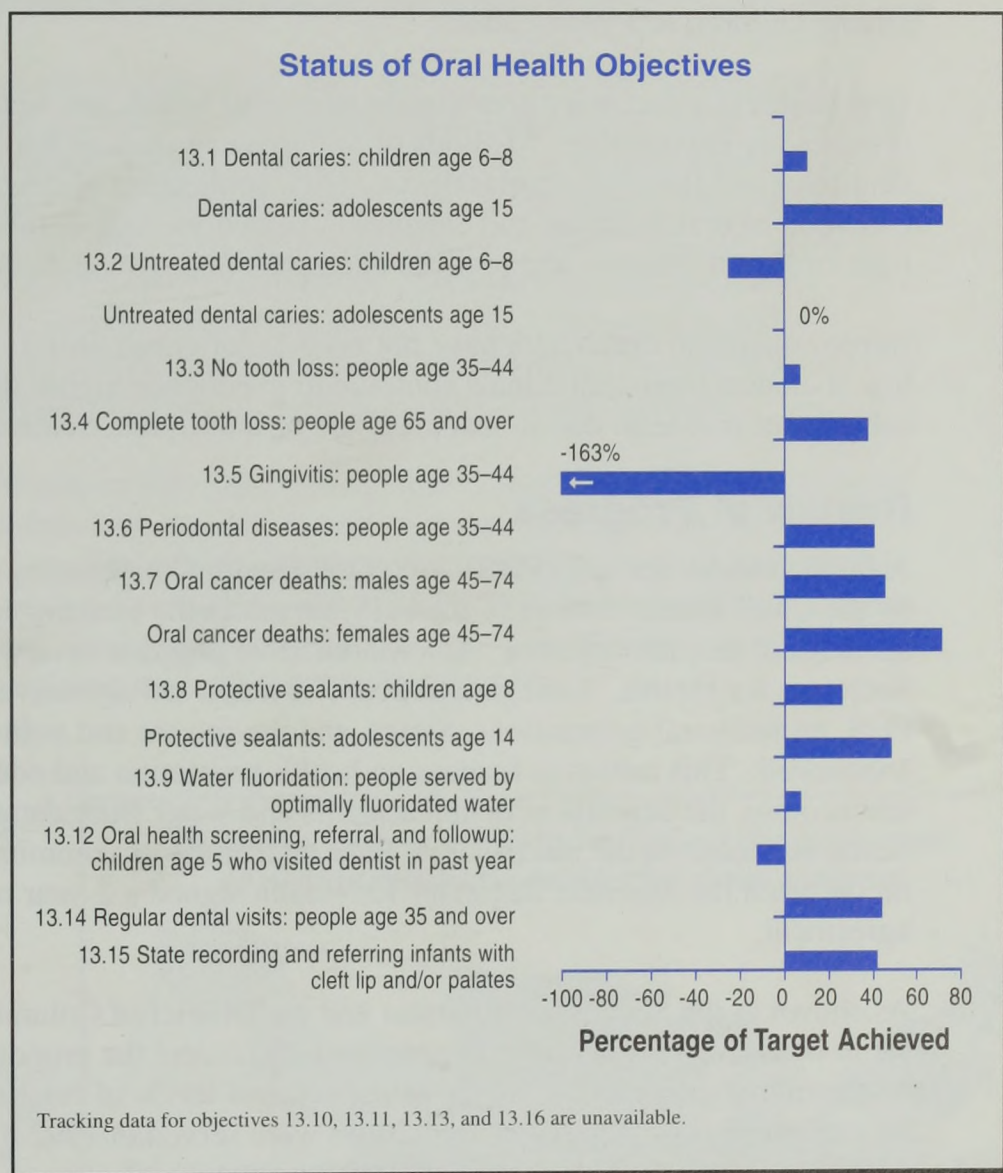
Source: CDC/Center for Infectious Diseases, 1992

Available data indicate that computer utilization in the practice of pharmacy has steadily increased. In 1992, approximately 95 percent of pharmacies incorporated the use of computers in their pharmacy practice. During September 1994, HCFA published a rule implementing the Omnibus Budget Reconciliation Act of 1990 requirements with regard to drug utilization reviews (DUR). The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate and medically necessary and that they are not likely to result in adverse medical effects. The regulations require a review of drug therapy before each prescription is filled or delivered to a recipient. The review is done at the point of sale and carried out in part to detect drug-disease contraindications and drug- or allergy-related interactions. Counseling and maintenance of patient profiles by the pharmacist are also required. Although these regulations apply only to the Medicaid program, most States are in the process of expanding the requirements to all prescriptions filled by pharmacists. For many patients covered by third party insurers, the pharmacist effects linkage by obtaining preauthorization to fill the prescription. When he or she does this, the insurer checks the patient's record of prescriptions received from all sources. Pharmacists are accomplishing this public health service by the use of a variety of available computer software packages and the use of computerized patient profiles. In addition, many chain pharmacies are implementing linked computer systems that enable the patient to have a prescription filled at any store in that specific chain with the pharmacist having the capability of retrieving that patient's profile for purposes of efficient patient counseling and review.

Baseline data have been determined for Objective 12.6 to extrapolate the percentage of primary care providers that routinely review medications with older adults. Separate data for specific primary care provider groups were derived from a 1992 survey, showing that 70 percent of family physicians routinely reviewed current medications and 63 percent reviewed medications when prescribing. Among internists, 84 percent routinely counseled elderly patients on their current regimen of medications and 77 percent reviewed new prescriptions as they were prescribed.

1995 Revisions

Two new objectives have been added to the Food and Drug Safety priority area. One tracks the proportion of serious adverse event reports that are voluntarily forwarded to FDA. The other facilitates an increase in the proportion of people who receive useful information about their drug regimens when being counseled by both prescribers and dispensers of medications by measuring patient assessment of counseling efforts. This objective complements objective 12.6, which tracks the extent to which primary care providers are counseling older adults. Additionally, the language of objective 12.6 has been modified to expand the tracking of patient counseling to include both primary care providers and dispensers of medication. This change will facilitate tracking pharmacist counseling at the point of patient contact when prescriptions are dispensed. Another revision has been made to objective 12.4 to address the adoption of the new Food Code 1993 by the States. The goal of the objective is to have at least 70 percent of the States adopt this uniform code for food storage, preparation, and sanitation by restaurants, food vendors, and institutional food service providers by the year 2000.



Lead Agencies: *National Institutes of Health*

Centers for Disease Control and Prevention

ORAL HEALTH

The improvement in oral health in America is one of the major public health success stories of this century. Public health measures such as fluoridation of water, preventive approaches available for self-care (fluoride), and professional dental services (fluorides and dental sealants) have resulted in dramatic reductions in dental caries among children and young adults.

Oral health is a necessary prerequisite to overall health and well-being. Most oral diseases are preventable. Methods of oral hygiene such as brushing with fluoride dentifrice and flossing, regular dental visits, application of dental sealants, early detection of oral diseases, and changes in behaviors such as tobacco use can eliminate most oral diseases and produce enormous improvements in oral health.

Improvements in oral health have not been experienced uniformly. Minorities and low socioeconomic individuals continue to experience higher disease levels and subsequent problems due to inappropriate or inadequate treatment.

Review of Progress

A Public Health Service (PHS)-wide Oral Health Coordinating Committee, chaired by the Chief Dental Officer of the PHS, serves as the steering committee for co-lead agencies of this priority area. At a March 1992 progress review with the Assistant Secretary for Health, "Oral Health 2000," a major collaborative initiative among PHS, professional associations, States, and the private and voluntary sector was announced. This initiative focuses on health promotion and education, the risks of tobacco use, the benefits of dental sealants and water fluoridation, and access to dental services. In the fall of 1994, PHS reaffirmed its commitment to this collaboration when the Assistant Secretary for Health signed a 2-year memorandum of agreement.

As shown in the State map, 20 States and the District of Columbia exceed the target set in objective 13.9 to increase to at least 75 percent the proportion of people served by community water systems providing optimal levels of fluoride. Approximately 62 percent of people in the United States were served in 1992 by optimally fluoridated water, a rate stable since the 1989 baseline.

Comprehensive national oral epidemiology surveys are conducted every 5 to 10 years. The baselines for objectives 13.1 through 13.6 were established using national surveys conducted during 1985–87. Progress on these objectives is being assessed using the National Health and Nutrition Examination Survey III (NHANES III), phases I and II (1988–1994). Data from NHANES III also are being used to evaluate progress on dental sealants and dental visits. National Health Interview Surveys provide data to assess programs for other objectives. The levels of oral health, as measured by the clinical criteria in objectives 13.1 through 13.4 and 13.6, are stable or improving slightly. Progress on subobjectives using these clinical criteria illustrates the same trends, either stable prevalence or slight improvements. Deaths due

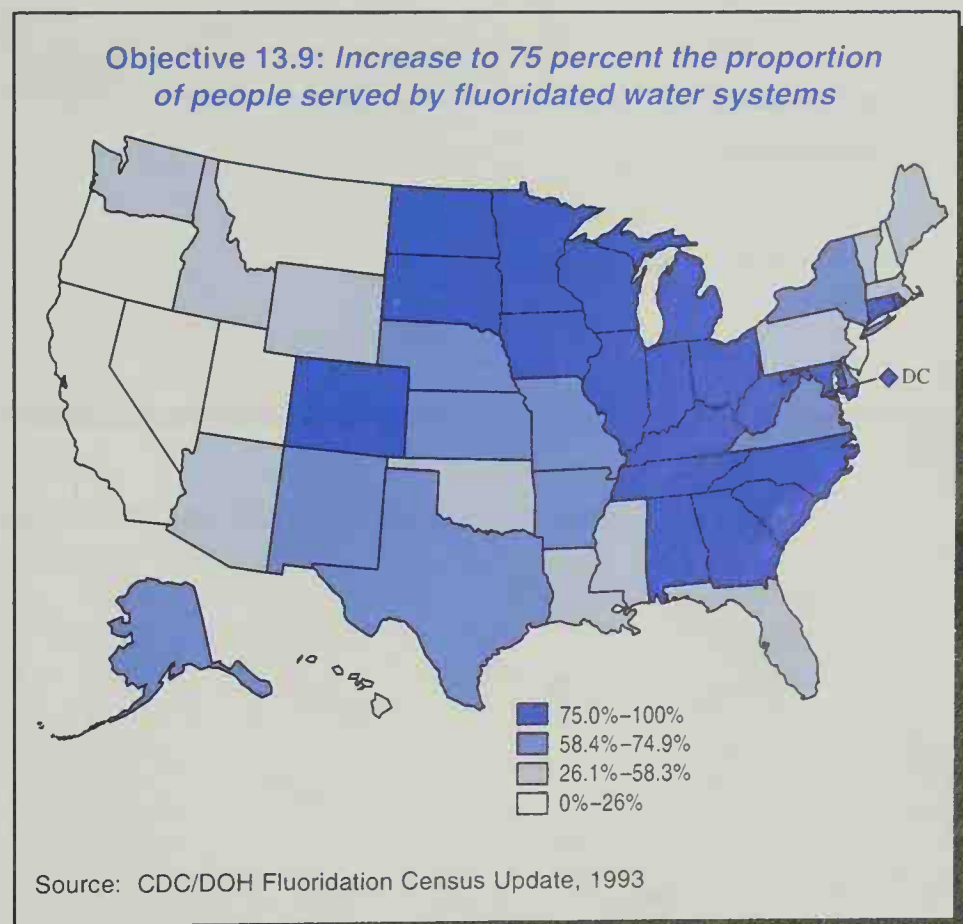
to oral cancer have decreased. Self-reported total tooth loss (edentulousness) has been reduced. However, gingivitis for people aged 35–44 has increased, a trend that may reflect increased awareness and reporting of gum disease. Placement of dental sealants on children's teeth is increasing. Among adults 35 and over, a slightly higher percentage are seeking dental care. In contrast, the proportion of 5-year-old children visiting the dentist in the past year has declined.

A number of local area prevention projects are showing excellent outcomes. In a three community study, 52 percent of the children were caries free in the optimally fluoridated area compared to 40 and 25 percent in the two sites with minimal fluoridation. The contrast in caries-free rates between the two minimally fluoridated communities appears to be due to the difference in uses of dental sealants. In the community with 40 percent caries-free children, 54 percent had dental sealants; in the community with 25 percent caries-free children, only 7 percent had dental sealants; in the optimally fluoridated community, 6.5 percent of the children had dental sealants. Such data illustrate the impact of multiple interventions.

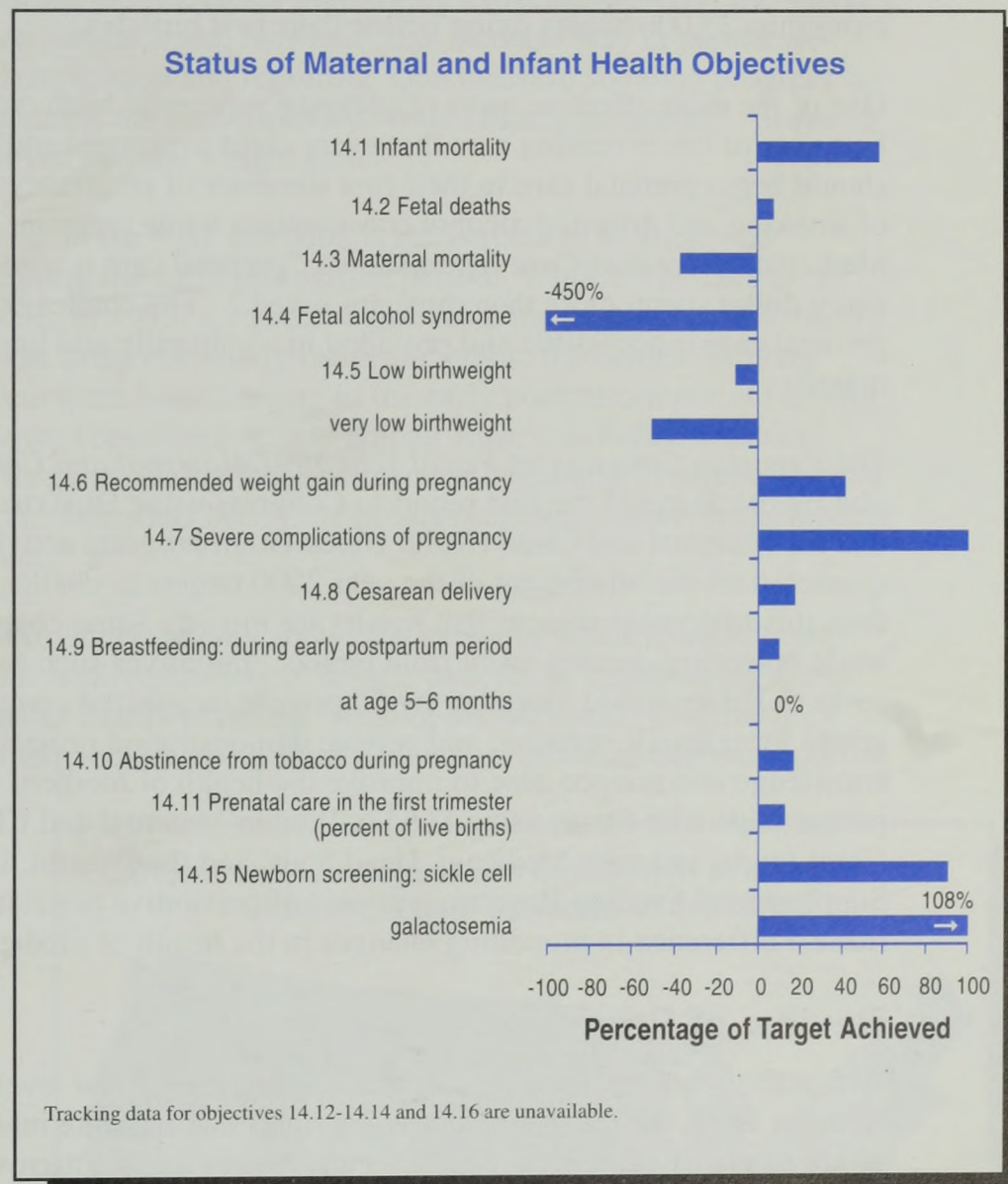
Meeting the year 2000 oral health objectives remains a challenge. Because of fewer State and local dental directors, declining funds devoted to dental care from block grants, and the lack of comprehensive dental service programs in many community and migrant clinics, moving the Nation's oral health closer to the established targets will require more effort. Real progress will occur only if interventions to change behaviors and prevent disease are instituted in communities.

1995 Revisions

The principal revisions in the Oral Health priority area are the addition of special population targets to focus attention on narrowing the disparities between groups who are at higher risk than the total population. An American Indian/Alaska Native subobjective was added to objective 13.4 to reduce edentulism. New subobjectives for black males and black females were created for objective 13.7 to reduce deaths due to cancer of the oral



cavity and pharynx. Special population targets were established for blacks and Hispanics to track the use of dental sealants, the percentage of children visiting a dentist before entering school and appropriate feeding practices to prevent baby bottle tooth decay. New subobjectives for adult dental visits were established for blacks, Mexican Americans, and Puerto Ricans. Because of the importance of smokeless tobacco cessation in reducing oral cancer, objective 3.9 will be shared in this priority area.



Lead Agency: *Health Resources and Services Administration*

MATERNAL AND INFANT HEALTH

Infant mortality is an important measure of a Nation's health and a worldwide indicator of health status. Compared with other industrialized nations, the United States ranks 24th in infant mortality rate (1991). The objectives in the Maternal and Infant Health priority area of HEALTHY PEOPLE 2000 seek to reduce the tragedy of more than 33,000 babies dying before their first birthday.

One of the most effective ways of ensuring successful birth outcomes and a healthy first year of life is making sure that every child is planned and wanted. Women should begin prenatal care in their first trimester of pregnancy and avoid the hazards of smoking and drug and alcohol consumption while pregnant. As the Institute of Medicine's *Access to Care* report shows, "prenatal care is a good investment—for every dollar spent, more than three are saved." The challenge is to ensure that prenatal care is accessible and provided in a culturally and linguistically sensitive manner.

The Report to Congress on Fiscal Year 1991 Maternal and Child Health Activities and Health Status is the first report to Congress using HEALTHY PEOPLE 2000 indicators for Maternal and Child Health Block Grant program activities. This report characterizes the attainment of the year 2000 targets as challenging and shows, as does this midcourse review, that results are mixed: Some objectives show progress while others are moving away from targets. Initiatives such as Healthy Start, which seeks to reduce infant mortality by 50 percent in selected communities, and SPRANS grants for research, training, and service demonstration projects help build the knowledge and science base to improve the health of mothers and children. Through partnerships with States using \$664 million in Maternal and Child Health Block Grant funds, and with Medicaid, Head Start, and the Women, Infants and Children Supplemental Feeding Program, systems of preventive population-based services make a difference in propelling changes in the health of mothers and their children.

Review of Progress

Although the infant mortality rate has reached record low levels, 8.5 per 1,000 live births in 1992, the rate for blacks is 2.4 times that of white infants. The disparity in infant mortality rates between blacks and whites has not narrowed between 1987 and 1992. Among Hispanics, Puerto Ricans have the highest infant mortality rates; unlike the other Hispanic population groups, their infant mortality rates have risen over the past 5 years. Fetal mortality rates have declined slightly while maternal mortality rates have risen.

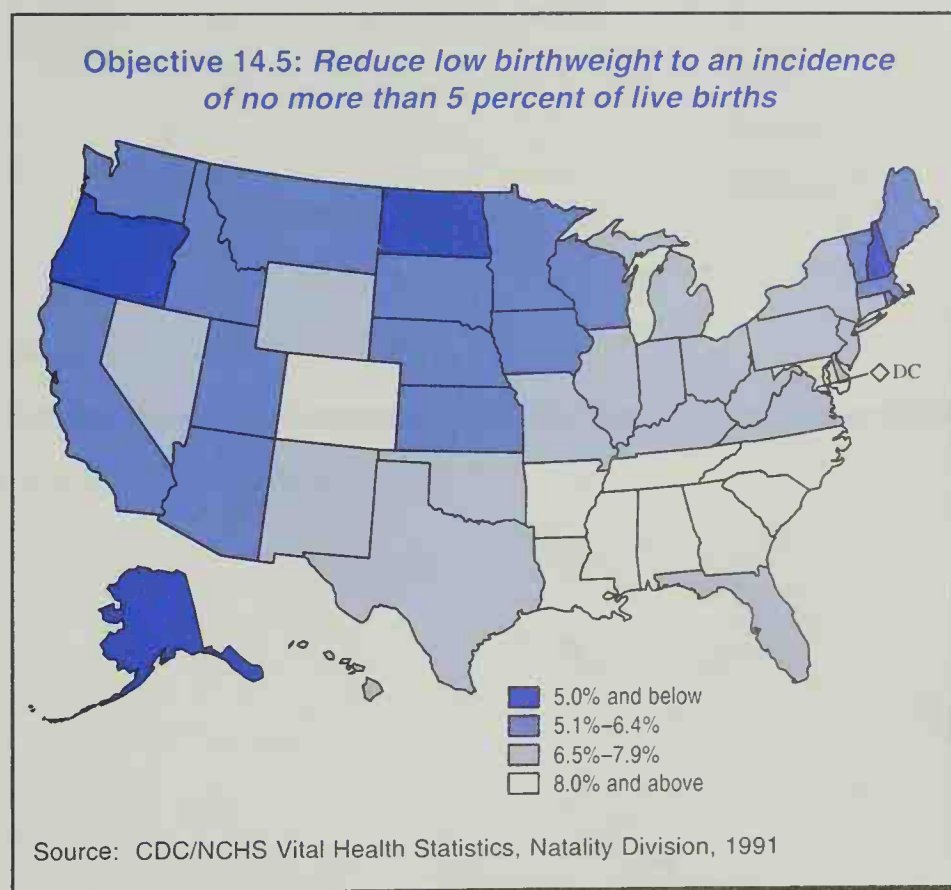
Low birthweight and very low birthweight rates have increased, with 7.1 percent of babies being born under 5.5 pounds (2,500 grams) and 1.3 percent of babies weighing less than 3.3 pounds at birth (1,500 grams) in 1992. The increase in low birthweight is due largely to the steady increase of preterm births since 1981. However, more recent interventions such as surfactant treatment have improved survival of low birthweight infants.

Severe complications of delivery have decreased sufficiently to meet the year 2000 target. Cesarean delivery rates also have fallen. While the percent of women abstaining from tobacco use has moved toward the target, the number abstaining from alcohol was 81 percent in 1993. One indicator of alcohol use during pregnancy—the number of babies born with fetal alcohol syndrome—has increased. The number of hospitals participating in the Birth Defects Monitoring Program, which is the source of data for this objective, has declined. However, this increase may in part be explained by improved identification and reporting. One measure showing progress is the percent of women gaining the recommended weight during pregnancy. Some 75 percent of women achieved optimal weight gain.

Another objective moving in the right direction is the percent of women who breastfed their infants during the early postpartum period. While 56 percent of all women were breastfeeding in 1993, a 2 percent gain from the baseline established in 1988, there has been more progress among racial and ethnic minorities. Among black mothers, 31 percent were breastfeeding in the early postpartum period; among Hispanics, 56 percent were breastfeeding; and among American Indians/Alaska Natives, 51 percent. The gains among these women are beginning to narrow the gap with the total population. There has been little progress among women breastfeeding 5 to 6 months postpartum.

A 1992 Primary Care Providers' Survey shows the extent to which clinicians are routinely inquiring about family planning of female patients of childbearing age or providing counseling about family planning. Among pediatricians, 18 percent reported that they routinely inquire about family planning, while 36 percent reported that they routinely counsel about family planning. For other providers the findings were: family physicians, 28 percent and 36 percent; obstetricians/gynecologists, 48 percent and 65 percent; and nurse practitioners, 53 percent for both services.

For several objectives there are no consistent tracking data sources. Baselines have not been established yet for the objectives seeking to increase the proportion of pregnant women and



infants who receive risk-appropriate care and the percent of babies who are receiving recommended primary care services at the appropriate intervals. No update is available for women receiving screenings for fetal abnormalities.

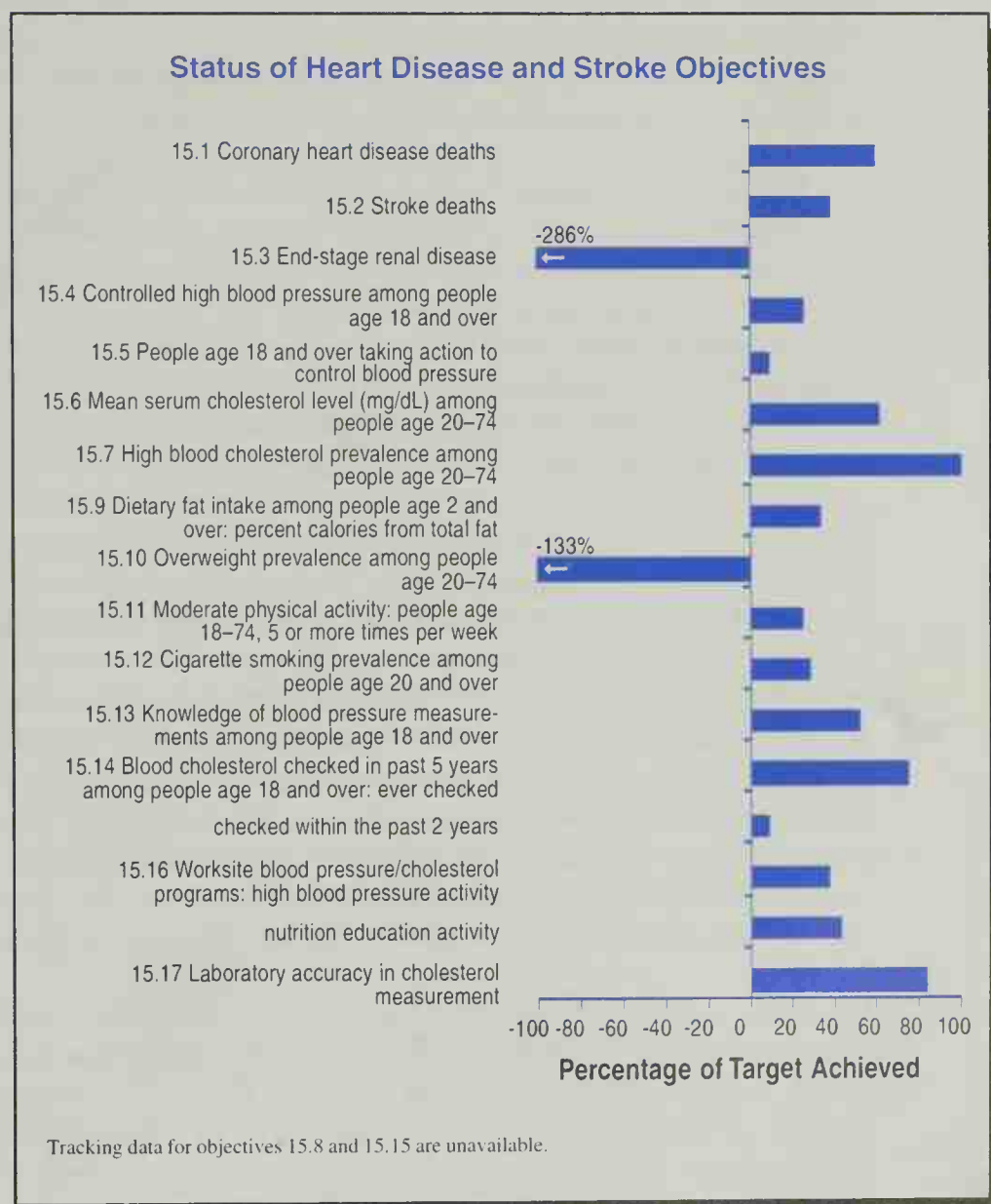
While a summary statistic is not available on the percent of newborns being screened and treated for genetic disorders, two measures show significant increases in screening. Based on 43 States reporting in 1993, 89 percent of infants were screened for sickle cell disease. In the 38 States reporting, 97 percent of infants were screened for galactosemia.

1995 Revisions

A new objective has been added to track the incidence of spina bifida and other neural tube defects (NTDs). This objective, in place for the 1980s, seeks reductions in birth defects. The potential to reduce spina bifida and other NTDs by 50 percent is suggested by data showing the association of risk reduction with consumption of 400 micrograms of folic acid prior to pregnancy.

Several special population targets have been added: reductions in low birthweight and very low birthweight for Puerto Ricans; and decreased pregnancy complications for blacks.

The targets for objective 14.10 for marijuana and cocaine have been revised to 100 percent. New baseline data show that 99 percent of pregnant women abstain from cocaine use and 98 percent abstain from using marijuana.



Lead Agency: *National Institutes of Health*

HEART DISEASE AND STROKE

Over the past 25 years, dramatic improvements have been made in reducing the death toll from heart disease and stroke: death rates for coronary heart disease and stroke have declined by 49 percent and 58 percent, respectively. Much of the success is a result of a dual strategy that includes a high-risk and population approach. Improved high blood pressure control and high blood cholesterol control have been the principal initiatives. Substantial evidence supports that prevention through lifestyle improvements is effective.

The National High Blood Pressure Education Program (NHBPEP) and the National Cholesterol Education Program (NCEP)—both coordinated by the National Heart, Lung, and Blood Institute (NHLBI) in partnership with other organizations concerned about cardiovascular disease across the Nation—have been recognized for improving awareness of the effects of high blood pressure and high blood cholesterol on health and for subsequent behavioral changes. The two committees that guide these programs also serve as the HEALTHY PEOPLE 2000 working groups. More than 40 nonprofit organizations serve on each committee.

Blood lipid levels, specifically total cholesterol, have been reduced as Americans have adopted healthier eating habits. Average blood pressure levels have dropped, and blood pressure control is among the best in any industrialized nation. Cigarette smoking rates have declined over the years with fewer people beginning to smoke. Physicians now are more likely to begin therapy for the management of hypertension at lower diastolic blood pressures; treatment rates have doubled; and control rates have more than tripled. The levels of blood cholesterol have declined steadily, and in 1990 approximated levels recommended by the NCEP. High blood pressure prevalence and cholesterol levels in the United States have declined significantly because of earlier and increased screening, detection, and management, coupled with self- or provider-initiated changes in diet and other lifestyle improvements.

Much more remains to be done. Heart disease and stroke continue to affect more Americans than any other disease: heart disease is the leading cause of death and stroke was the third leading cause of death (1992). The impact of premature morbidity from cardiovascular diseases on the ability of affected individuals to function independently or to participate fully in the activities of daily living is devastating in terms of personal loss, pain, suffering, the effects on families and loved ones, and economic burden. The annual national economic impact of cardiovascular disease is estimated at \$190 billion as measured in health care expenditures, medication, and lost productivity due to disability and death.

Major disparities and gaps exist among population groups and geographic regions, with a disproportionate burden of death and disability in minority and low-income populations. Although deaths from coronary heart disease and stroke have decreased for the total population and for blacks, mortality is higher and the rate of decline is less for both causes among blacks than the total population. Black Americans also suffer appreciably higher rates of hypertension and incidence of end-stage renal

disease (ESRD) than do whites. Stroke mortality and morbidity are particularly concentrated in the southeastern United States with the age-adjusted stroke mortality rate in this "Stroke Belt" more than 10 percent higher than the U.S. average. The rates of decline in this area are faster than elsewhere, but the absolute rate is still much higher, with the highest rates among blacks.

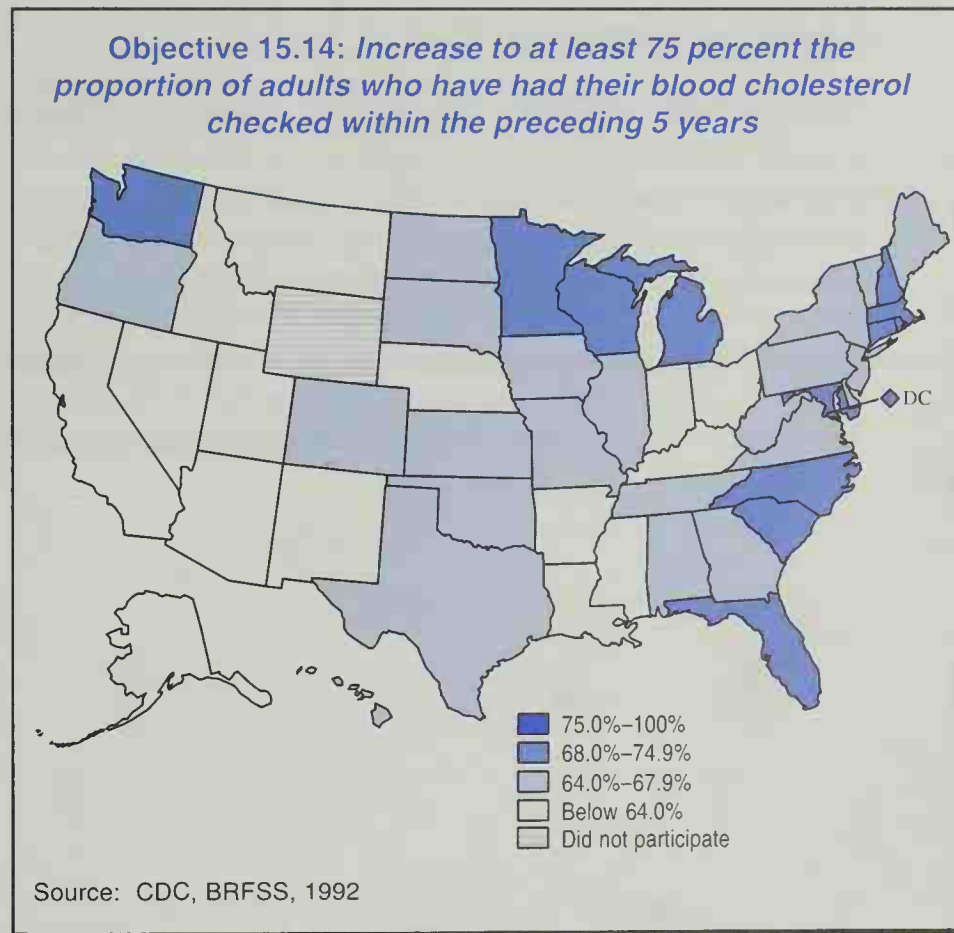
The challenge in this priority area will be to keep prevention in the forefront and to rely less on control and treatment. This strategy includes more attention to bridging the gap between research and people, between science and communities, and to creating incentives that focus limited resources on the prevention and control of chronic diseases.

Review of Progress

The significant progress in this priority area reflects the effectiveness of science-based public health strategies that rely on partnerships among the Federal Government, State and local health departments, and the private sector in combating the barriers to reducing heart disease and stroke. In only two of the 17 objectives—those related to reversing the increase in end-stage renal disease and reducing overweight—do data indicate movement away from the targets.

Several hypotheses have been posed to explain increased rates for ESRD, including that hypertension is not being treated adequately or at low enough levels to protect the kidneys, that diabetes prevalence is increasing, or that an ascertainment bias is at work (i.e., better equipment and diagnoses are available to detect more ESRD).

Progress on increasing the number of adults with high blood cholesterol who are taking action to reduce their cholesterol levels should be measurable by the National Health and Nutrition Examination Survey (NHANES III). For the remaining 14 objectives, appreciable improvements are being made, including success in meeting the year 2000 target for reducing the prevalence of high blood cholesterol.



The principal prevention strategy for reducing heart disease and stroke focuses on large-scale public and professional education programs—such as the NHBPEP and the NCEP at the Federal level. Such programs involve the major medical and health organizations, voluntary health organizations, community programs, government agencies, and State health departments.

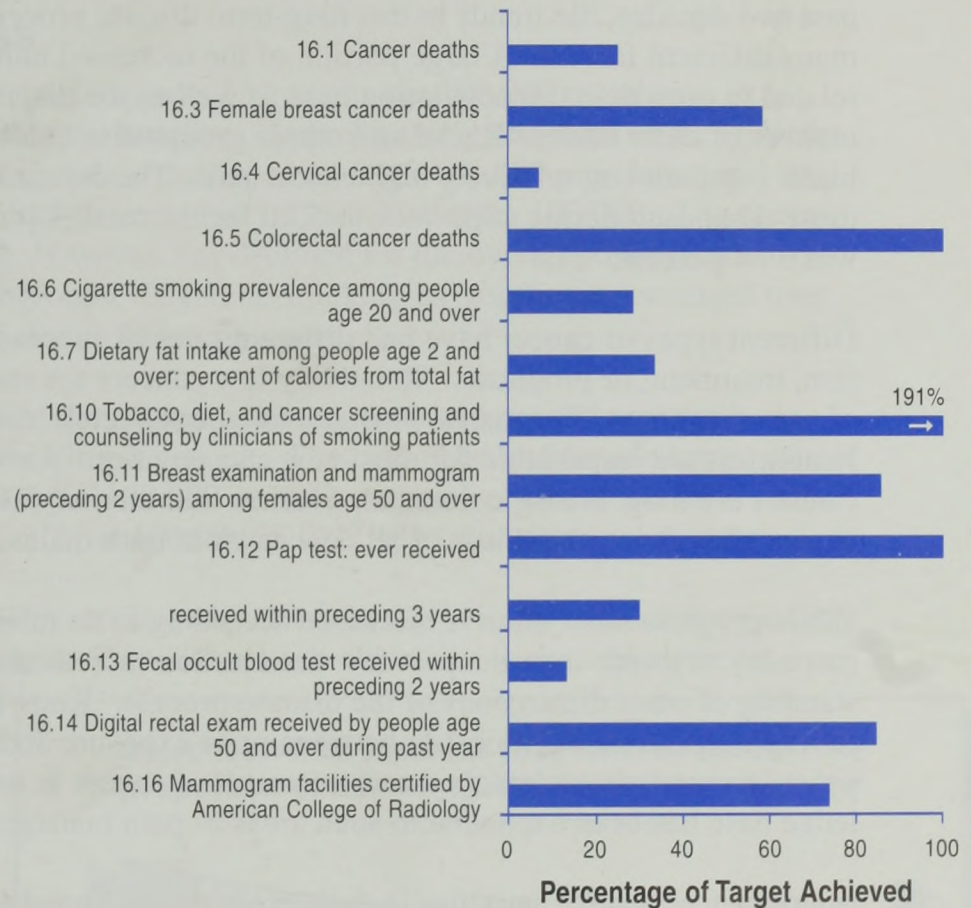
Within the Public Health Service, as a part of the Food and Drug Administration's mandate to develop a new food label, NHLBI has assisted in the development of specific criteria for the amount of total fat, saturated fat, cholesterol, and sodium listed on the label. NHLBI has incorporated the new food label in a variety of its patient and public education materials. In May 1994, in honor of both National Physical Fitness Month and National High Blood Pressure Month, NHLBI joined with the President's Council on Physical Fitness and Sports as one of its Presidential Fitness Partners to promote "Get Moving, America." NHLBI featured messages on physical activity on its Healthbeat Radio Network and offered a number of educational and community activities, including a toll-free number for the public to learn about ways to prevent hypertension and increase physical activity.

The American Academy of Pediatrics, the American Dietetic Association, and the American Heart Association have been natural allies with NHLBI in the development of educational and training materials such as video tapes and kits for physicians, nurses, and dietitians. In recognition of the faith community as a means of reaching high-risk populations, partnerships have been formed to provide high blood pressure screenings in religious institutions and settings.

1995 Revisions

The midcourse changes in this priority area relate to improvements in data sources and the addition of new subobjectives for special population groups—in particular, Hispanic or Mexican Americans—as new baseline data have become available. New subobjectives for specific population groups were added to objectives related to high blood pressure control, overweight prevalence, moderate physical activity, blood pressure checks, and blood cholesterol checks. Regarding the objective to reduce dietary fat intake, the original target population was changed to people aged 2 and older, based on better data available from the 1976–80 National Health and Nutrition Examination Survey and 1989–91 Continuing Survey of Food Intakes by Individuals.

Status of Cancer Objectives



Tracking data for objectives 16.8, 16.9, and 16.15 are unavailable.

Objective 16.2 (slow the rise in lung cancer deaths) cannot be displayed as a percentage of target achieved.

Lead Agency: *National Institutes of Health*

CANCER

Cancer is a leading cause of morbidity and mortality in the United States. While deaths from stroke and heart disease have continued to decline over the past 25 years, the burden and consequences of cancer have increased. If current trends continue, cancer may become the leading cause of death early in the next century.

Although overall cancer incidence and mortality have grown considerably over the past two decades, the trends in this long-term disease process vary according to many different factors. A large portion of the increased number of cancer cases are related to growth in the population base as well as the disproportionate growth in the number of older adults. Racial and ethnic groups also exhibit differences, with the black population at relatively high cancer risk. The 5-year relative survival rate for those diagnosed during 1983-89 was 53.0 for the total population; for blacks this rate was 39.4 percent.

Different types of cancer have had different rates of success in terms of early detection, treatment, or prognosis. Relatively few cancers are responsible for the majority of new diagnoses. For males, prostate, lung, colorectal, bladder, and non-Hodgkin's lymphoma are responsible for most new cancer cases. For females, the leading five cancers are lung, breast, colorectal, ovarian, and uterine. These five cancer sites account for about two-thirds of all new cases in both males and females.

While progress most often is discussed according to its relationship to morbidity or mortality, research over the past few decades has increased substantially our understanding of other dimensions of the disease process. Knowledge has increased, for example, about the relationship between prior exposure and disease manifestation years later and about detection and treatment of cancer in its early stages. The knowledge base has been expanded in such areas as pain management and quality of life.

Major cancer control activities include programs designed to increase the availability and use of breast and cervical cancer screening as well as followup care by health providers for hard-to-reach populations such as low-income, low-education, and older minority women. The 5-A-Day for Better Health Program, a public-private partnership initiative, encourages consumers to eat at least five servings of fruits and vegetables daily in order to reduce the likelihood of developing cancer.

The American Stop Smoking Intervention Study (ASSIST), which began a 5-year intervention phase in 1993, is a collaboration among the National Cancer Institute, the American Cancer Society, and the health departments of 17 States. The purpose of ASSIST is to demonstrate that the widespread application of the best available strategies to prevent and control tobacco use can help accelerate downward trends in smoking rates, particularly among groups whose prevalence rates remain a problem such as adolescents, women, medically underserved people, less educated people, and several minority populations.

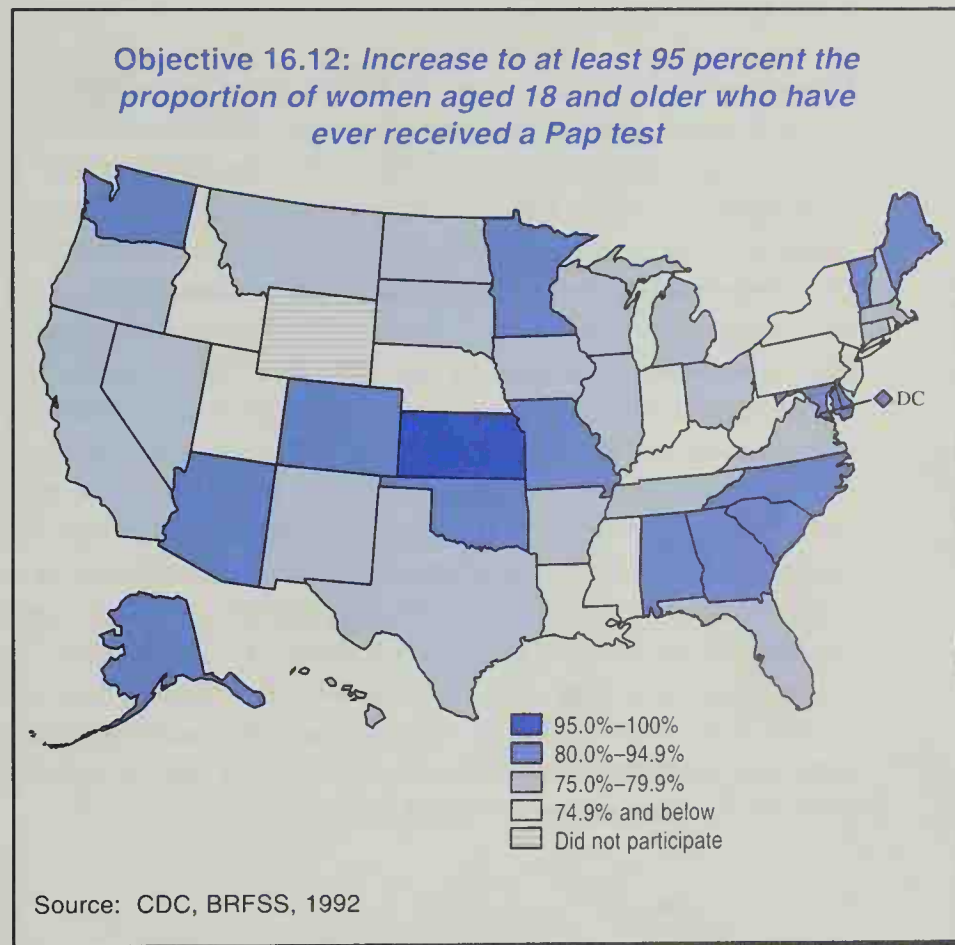
Concern over the accuracy of clinical testing, including Pap smears, led to passage of the Clinical Laboratory Improvement Amendments in 1988. Federal regulations require proficiency testing of the laboratories and doctors' offices performing these tests. The implementation of these regulations currently is in process, with the earliest data on compliance expected in 1995. Product safety regulation and public educational efforts also are ongoing to monitor the relationship between exposure to artificial sources of ultraviolet light and the development of skin cancer.

Review of Progress

The overall rate of cancer mortality was 134 deaths per 100,000 population in 1992—a slight increase since the baseline. Approximately one-third of these deaths are related to tobacco. Lung cancer deaths, at 39.6 per 100,000 population in 1991, have increased since the 1987 baseline rate of 38.5 deaths per 100,000. The prevalence of cigarette smoking, however, has declined for the overall population as well as for most population subgroups. Cigarette smoking by youths has increased over the past few years after declining for many years.

Although mortality rates for some types of cancer such as lung and prostate have increased, others have shown improvement. The colorectal and female breast cancer death rates, at 21.9 and 13.2 per 100,000 in 1992, respectively, have declined. The cervical cancer death rate, 2.7 per 100,000 in 1992, also has improved slightly.

The risk reduction and health services objectives in this priority area are focused on cancer prevention and control. Two diet-related objectives seek to decrease fat intake and increase the consumption of fruits, vegetables, and grains. The data show modest improvements in dietary patterns over the course of the decade. With standard nutrition labeling now available on most food items, consumers may be better able to make informed choices about the food they purchase. Baseline data for another objective show that approximately one-third of the population is likely to take actions to limit their exposure to the sun.



Application of appropriate screening tests is linked to improved health outcomes. The proportion of women who have received screening tests such as mammography and Pap smears has improved substantially. However, the most recent data indicate that only one-half of women age 50 and older have received a mammogram within the past 1 to 2 years, and about three-quarters of all women have received a Pap test within the preceding 3 years. Only 30 percent of the population have received fecal occult blood testing within the preceding 2 years, and 33 percent have ever received a proctosigmoidoscopy.

1995 Revisions

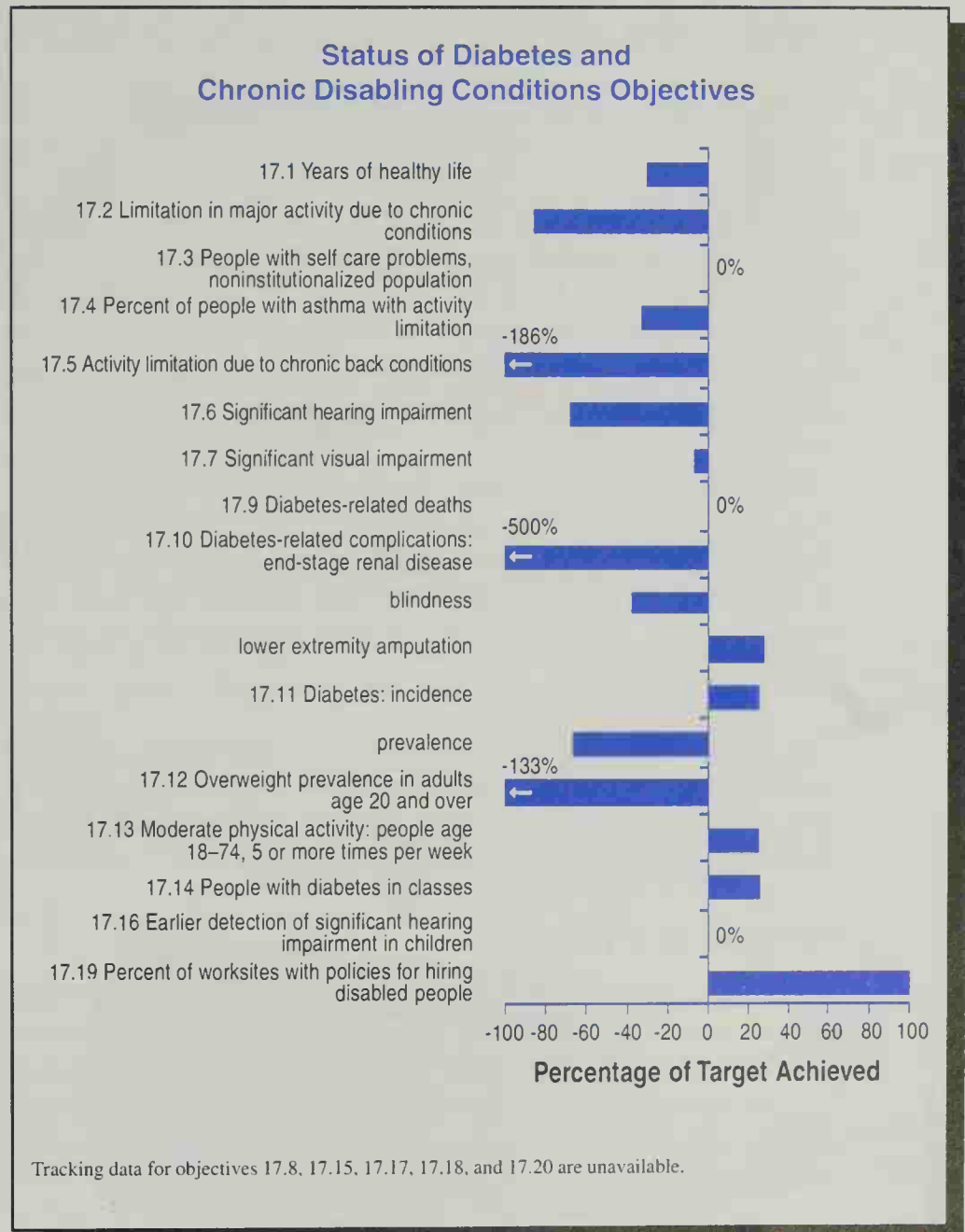
Because data show that certain population groups are at increased risk for various types of cancer, new subobjectives have been added to this priority area. In addition to the tracking of cancer mortality for the total population, the death rate now will be monitored for blacks. Special population objectives also were added for lung cancer deaths for females and for black males, and for colorectal cancer deaths for blacks. Breast cancer deaths will be tracked for blacks, and cervical cancer deaths for black and Hispanic females.

For the nutrition-related risk reduction objectives (16.7 and 16.8) the language was modified to include people aged 2 years and older. The text also was revised for objective 16.10 so that counseling by primary care providers includes a discussion of screening tests and risk factors associated with breast, prostate, cervical, and colorectal cancer. In addition, passage of the Mammography Quality Standards Act has led to a change in target for objective 16.16 because all mammography facilities must now fully comply.

Objective 16.11, which seeks to increase the proportion of women who receive clinical breast exams and mammography, has also been modified to include only women aged 50 and older. The U.S. Preventive Services Task Force, the American Academy of Family Physicians, and the American College of Physicians all recommend routine mammograms for women beginning at age 50. For women aged 50–69, clinical trials show a reduction of about one-third in the death rate under regular screening at an interval of 1 to 2 years. The trials to date, however, have not shown definitive results for women aged 40–49. The criterion for a recommendation that asymptomatic women aged 40–49 undergo routine mammography and clinical breast examination for the early detection of breast cancer would be the presence of data from a prospective randomized clinical trial showing a statistically significant reduction in mortality in the group invited to screening. The absence of such evidence, due either to lack of properly conducted studies or evidence of a benefit in well-designed studies with sufficient statistical power, means there can be no recommendation for the procedure, regardless of other factors, such as results from other types of studies. It is still early in the followup of some trials, and more definitive results may be available in several years. Because age is the greatest risk factor, periodic screening would be contraindicated only if a serious comorbidity were present for women aged 70 and over.

Women and health professionals should understand the essential facts about screening, particularly that risks involved with screening are greater for women in their forties, specifically the physical and emotional risks of false positive and false negative results. Mammography can find cancers in women in their forties, but it is not as effective; that is, it misses more cancers than mammography can detect in women 50 and older. Even though cancers are detected early through mammography, such early detection may not change the course of the disease. As stated previously, the trials have not shown a reduction in death rates in those who are screened regularly in their forties. Because the problems are clear and the benefits are as yet unproven, the decision for or against mammography in younger women needs to be discussed between the physician or other professional health care provider and the individual patient, with consideration of the known risk factors for the disease. As research continues on mammography at younger ages, women should discuss with their health care providers what is known about potential for benefit or harm and obtain advice on their individual risk for breast cancer so they can make informed decisions.

Diabetes and Chronic Disabling Conditions



Lead Agencies: *National Institutes of Health*
Centers for Disease Control and Prevention

DIABETES AND CHRONIC DISABLING CONDITIONS

Diabetes and other chronic disabling conditions lead to physical, emotional, social, and economic costs to individuals, families, and to the Nation. Since 1985, the total days of restricted activity due to disability have increased regardless of gender, race, or age. In 1992, they totaled 4.1 billion days. While life expectancy at birth has climbed steadily from 1988–92, years of healthy life have actually decreased.

Approximately 7 million people have been diagnosed with diabetes, a leading cause of death and disability among Americans; another 7 million may unknowingly have the disease. Diabetes is the seventh leading cause of death in the United States—with over 50,000 deaths attributed to it in 1992—a risk factor for cardiovascular disease, and the leading cause of lower extremity amputation, blindness, and end-stage renal disease. Diabetes contributes to over 100,000 additional deaths each year as well as increases the burden of suffering from acute and chronic complications, hospitalizations, and lost productivity. Blacks, American Indians/Alaska Natives, and Hispanics are disproportionately affected by the disease and its complications.

Chronic disabling conditions caused major activity limitations for 10.6 percent of the U.S. population in 1993—an increase from 9.4 percent in 1988. For some people, these limitations are minimal and confined to a particular dimension of activity. For as many as 9 million people, functional limitations are so severe that individuals are unable to work, attend school, maintain a household, or perform activities of daily living.

This priority area focuses on the need for prevention of disabilities; early diagnosis and treatment of chronic conditions; and provision of information, skills training, and support services to increase the ability of people to manage their conditions, to live independently, and to participate fully in their communities.

Review of Progress

While there has been progress for a few objectives and subobjectives within this priority area, much work remains if targets are to be reached. Data indicate movement away from the target for the years of healthy life objective—a summary objective for this entire priority area. There are similar trends for hearing impairment, overweight, and activity limitation due to asthma and chronic conditions, including back problems.

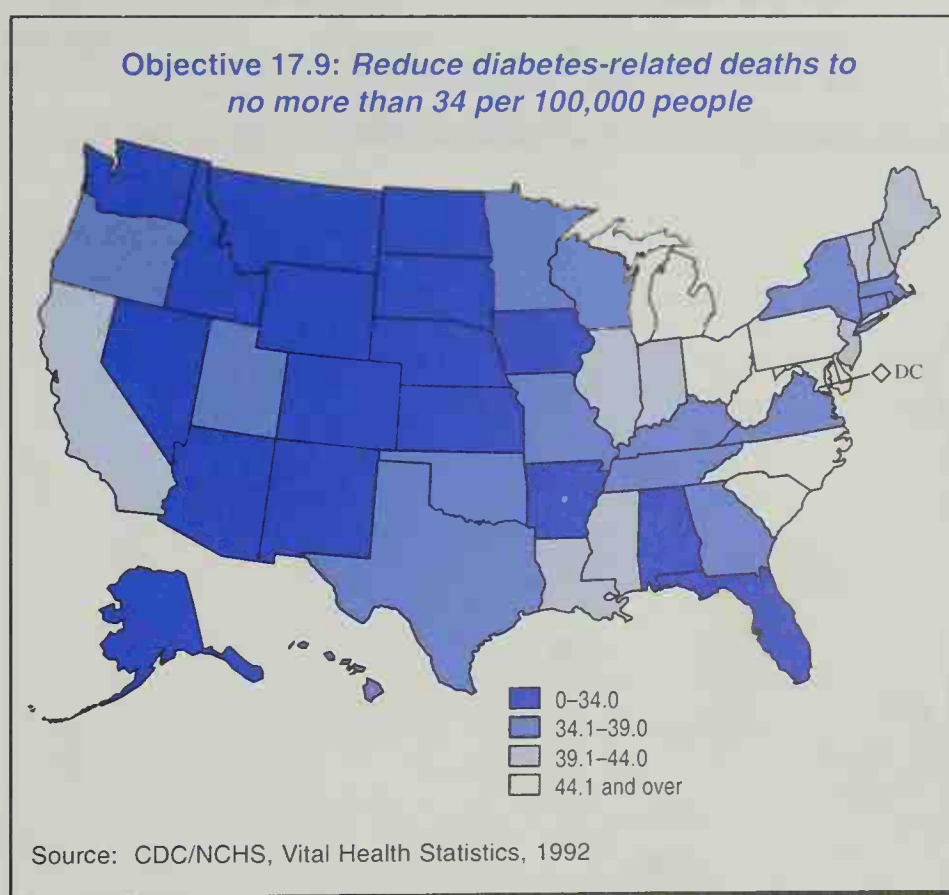
Little change from baseline has occurred for objectives addressing the ability of elderly people to perform self-care activities and diabetes-related deaths for the total population. The diabetes-related death rates appear to be rising for blacks and American Indians/Alaska Natives, although these increases may be a reflection of improved documentation of diabetes on death certificates. Except for a reduction in lower extremity amputations among people with diabetes, diabetes-related complications have not been reduced. End-stage renal disease has increased and is moving away

from the targets. The total prevalence of diabetes rose 7 percent, with increases in prevalence also for American Indians/Alaska Natives, and blacks.

Results for a number of other objectives are mixed. Although the rate of visual impairment in the total population rose slightly between 1986–88 and 1991–93, the rate decreased for people aged 65 and older. The risk reduction objectives show an increase in self-reported overweight and little change in the prevalence of moderate physical activity among people aged 18 and older. Some progress is evident in patient education for chronic and disabling conditions, with about 43 percent of people with diabetes and 10 percent of people with asthma receiving formal education classes in 1993. The target for programs and policies supporting employment of people with disabilities has been supported by passage of the Americans with Disabilities Act of 1990 prohibiting all employers from discriminating against qualified individuals because of disability.

Research in the area of diabetes and other chronic and disabling conditions, coupled with large-scale public and professional information campaigns and education efforts, may lead to greater inroads by the end of the decade. In a recent breakthrough in Type I diabetes, improved glucose control can delay substantially the onset and slow the progression of disease-related complications. Research scientists are engaged in clinical trials to explore prevention of both Type I and Type II diabetes.

Progress also occurs from work with communities to translate research findings into widespread practice and from major information and education initiatives related to diabetes and chronic disabling conditions. Such efforts include teaching patients with diabetes about glucose self-monitoring, educating primary care physicians and other practitioners about the importance of early detection and timely treatment of diabetic eye disease, stressing the importance of annual eye examinations and good vision care through the National Eye Health Education Program, establishing a National Obesity Information Resource Center, providing information and activities aimed at reducing the limitations and disabilities caused by asthma in school age children through the

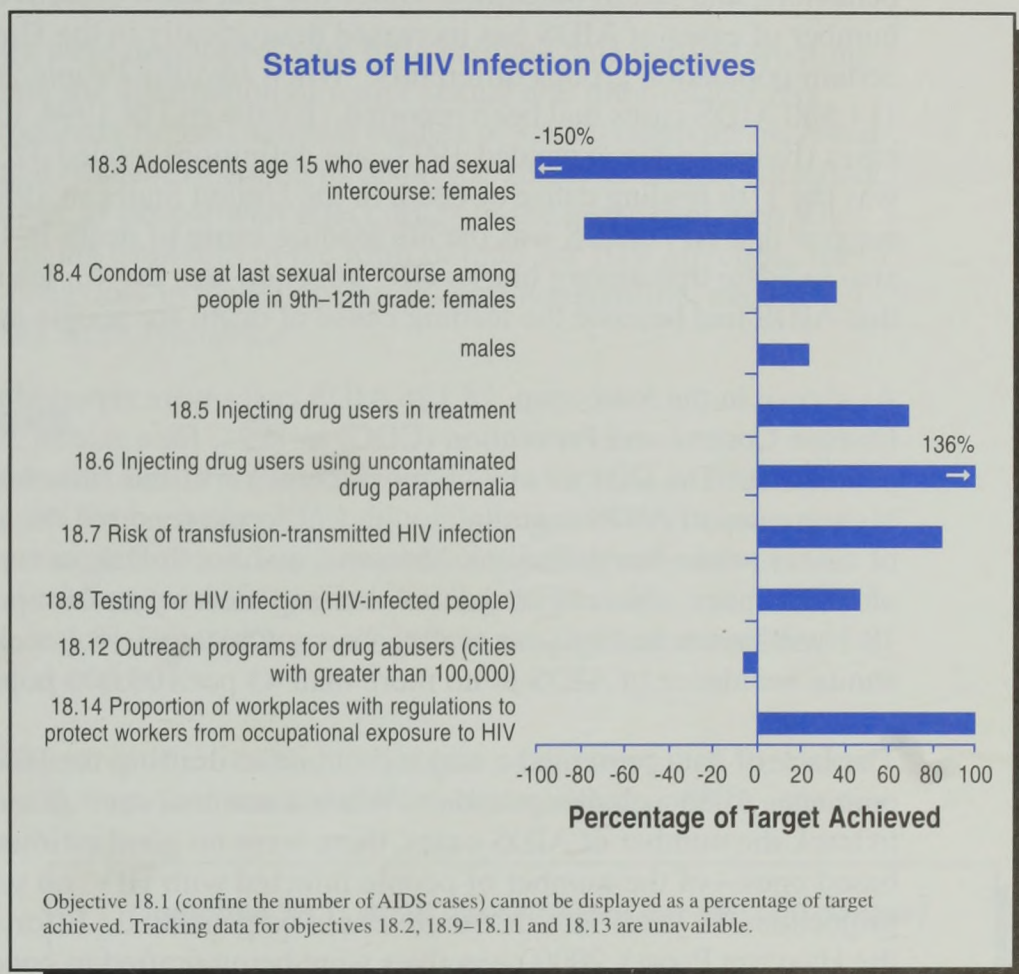


National Asthma Education Program, and sponsoring the Centers for Disease Control and Prevention (CDC) State-based Diabetes Control Programs that provide leadership and coordination for public health approaches to reduce the burden of diabetes.

To improve data in this priority area, the CDC's National Center for Health Statistics is conducting the 1994-95 National Health Interview Survey on Disability. Data are needed to track progress for objectives on mental retardation and perinatal mortality and congenital malformations related to complications of diabetes. Baseline data recently have been established for clinical assessments of childhood development and for functioning among older adults. Data still are needed for estrogen replacement therapy as well as service systems for children with chronic, disabling conditions.

1995 Revisions

Two new objectives have been added, reflecting scientific developments and newly available data. As a result of a recently available new therapy for preventing the usual recurrence of peptic ulcer disease, most of the direct and indirect economic costs as well as the impact on human suffering and disability associated with this disease now are avoidable. Consequently a new objective aimed at preventing recurrence of peptic ulcer disease and reducing its prevalence has been added. The second new objective seeks to increase the number of people with diabetes who receive annual dilated eye exams to detect treatable retinopathy. Recent studies have indicated that approximately 90 percent of blindness due to diabetes could have been avoided through secondary and tertiary prevention efforts. In addition, objective 22.4, regarding surveillance for special populations, has been added as a shared objective in priority area 17 to highlight the need for systematic national surveillance for people with disabilities. Objective 17.19 has been revised to be consistent with the Americans with Disabilities Act passed by Congress in 1992. Other changes focus on additional special population objectives, primarily for blacks and Hispanics.



Lead Agency: *Office of HIV/AIDS Policy*

HIV INFECTION

HIV/AIDS was unknown when the original 1990 objectives were developed in 1979–80. Ten years later, the HIV objectives for the year 2000 focused on HIV prevention, reduction of HIV incidence primarily through modification of high-risk behaviors, and health outcomes. Since the year 2000 objectives were written, the number of cases of AIDS has increased dramatically in the United States, affecting certain population groups differently. When *Healthy People 2000* was published, 114,500 AIDS cases had been reported. By the end of 1994, the number of AIDS cases (based on the expanded 1993 case definition) totaled 426,978. HIV infection was the 11th leading cause of death in the United States in 1989, and provisional data suggest that HIV/AIDS was the 8th leading cause of death in 1993. These same data also indicate that among blacks HIV infection was the 4th leading cause of death and that AIDS had become the leading cause of death for people aged 25–44.

As shown in the State map, 78,126 AIDS cases were reported to the Centers for Disease Control and Prevention (CDC) in 1994, for a rate of 30.0 per 100,000 population. The District of Columbia, New York, and New Jersey reported the highest rates of AIDS cases (although California reported the second highest number of cases), while North Dakota, Montana, and South Dakota reported the lowest rates of AIDS cases. (Note: The data on the map are by year of report, whereas objective 18.1 will be tracked by year of diagnosis.) Objective 18.1 seeks to confine the annual incidence of AIDS to no more than 43 per 100,000 population.

The lack of data presented a major problem in drafting the HIV objectives and continues to be a challenge today. While a national surveillance system was in place to track the number of AIDS cases, there were no good estimates—other than model-based ones—of the number of people infected with HIV; no scientifically justifiable projections 10 years into the future could be generated. Efforts were underway when the HEALTHY PEOPLE 2000 objectives were being drafted to conduct a feasibility study for the National Household Seroprevalence Survey; the study was not undertaken for methodological reasons and budgetary factors. All existing data were based on selected populations in certain localities. As of December 1994, 25 States required the reporting of HIV infection. These States have relatively low to moderate numbers of reported AIDS cases. Two other States require only pediatric HIV reporting.

The nature of the disease—with its relatively long incubation period between infection and symptoms—creates problems for tracking the progress of AIDS prevention efforts: most of the people who will be diagnosed as having AIDS between now and the year 2000 already have been infected. Tracking of AIDS case rates is complicated further by changes in the definition used for AIDS case reporting resulting from the ongoing evolution in the understanding of HIV disease and the care of HIV-infected people. With the last modification in the AIDS case definition in January 1993, the diagnosing and reporting of AIDS cases occurs earlier in the natural history of the disease. This change has resulted in a great but artificial increase in reported cases in 1993 that continued at a somewhat lower level in 1994. Surveillance data

on the number of AIDS cases are published both by year of report and by year of diagnosis; while the former are more readily available, the latter data more closely reflect the course of the epidemic. Trends in AIDS cases reflect technical and methodological factors, changes in survival rates, and differences in the course of the epidemic itself, thus making interpretation of HIV incidence trends difficult.

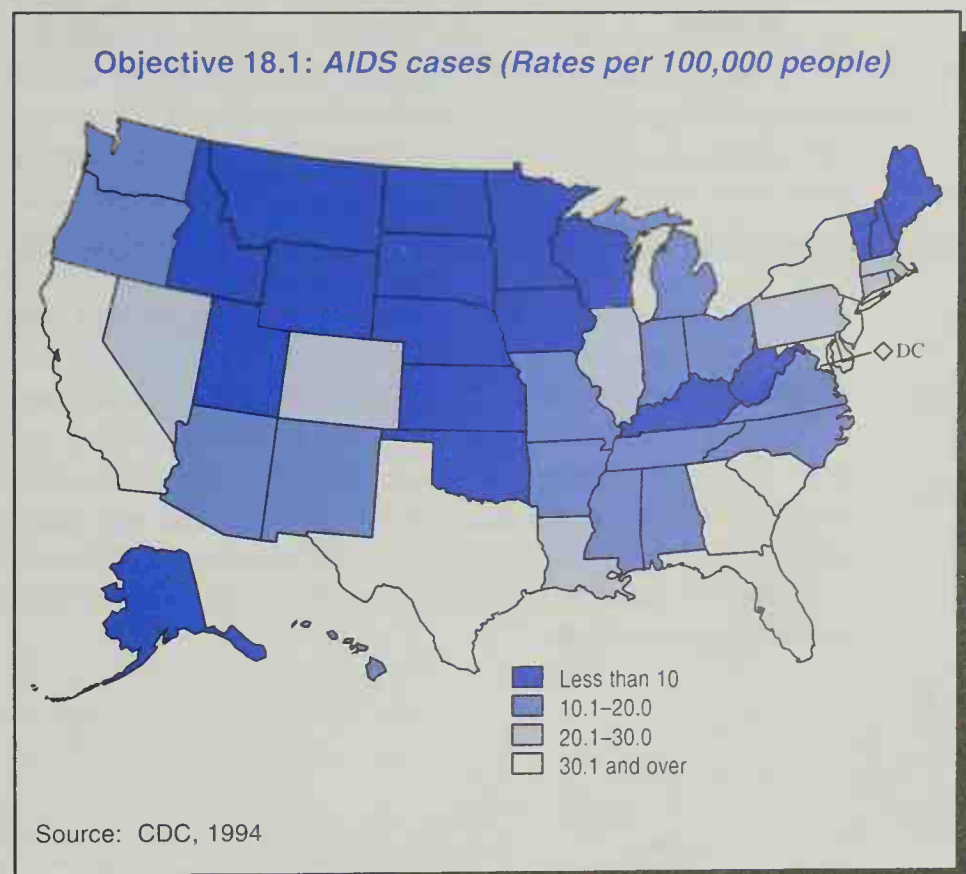
When the HIV objectives were developed, very little national data derived from the total population existed on the distribution of major sexual and drug-related risk behaviors. Two large, federally funded national studies of sexual behavior had been planned but were canceled because of concerns about the ability to collect such data. Without data on the number of people who inject drugs or the number of men who have sex with men, producing estimates in the form of rates for HIV infection, for AIDS cases, or for risk behaviors in these populations was not possible, even when reasonable numerator data were available.

Review of Progress

This priority area monitors the numbers of people infected with HIV or with AIDS and some of the risk factors for becoming infected, including adolescents who engage in sexual intercourse, use of condoms, number of injecting drug users in treatment, and transfusion-transmitted AIDS cases. Among the services and protection objectives are education, counseling, testing, and partner notification as well as prevention of occupational exposures.

Assessing progress for objective 18.1 is difficult because of the impact of the recent changes in the AIDS case definition discussed above. New estimates of HIV infection in the total population are not yet available.

Five objectives show progress toward the targets. These include condom use; the percent of injecting drug users in treatment or who use uncontaminated drug paraphernalia; the increased percentage of HIV-infected people who have been tested; and the increased safety of the blood supply. Two objectives aimed at reducing risks of HIV infection are going away from the target: the



number of adolescents engaging in sexual intercourse and the establishment of outreach programs for drug abusers. Baseline data for objective 18.9 show that clinicians do not routinely inquire about sexual practices of adolescents and adults. They do, however, provide counseling on HIV and sexually transmitted disease (STD) prevention more routinely. Nurse practitioners reported that they routinely inquired about sexual practices of 52 percent of their patients and routinely counseled 50 percent about HIV and STD infections. Tracking HIV education in colleges and universities requires baseline data. Regulations published by the Occupational Safety and Health Administration (OSHA) in 1991 protect workers from bloodborne infections including AIDS, thereby achieving the target for objective 18.14.

1995 Revisions

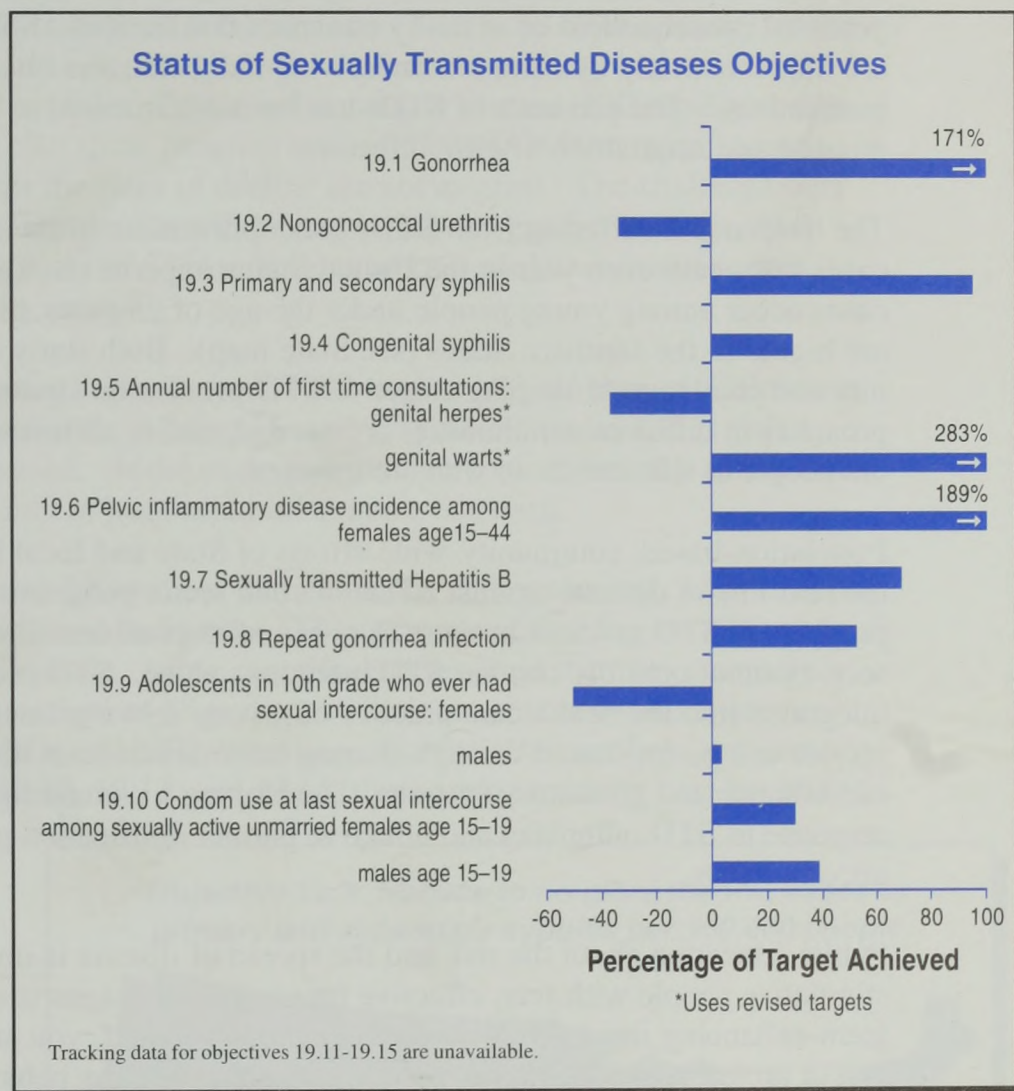
As the HIV epidemic has changed over time, new disparities have emerged in the rates of infection among subgroups of the population. The risks among these population groups have resulted in the addition of new special population targets. Women and injecting drug users are added to the special population targets tracked for AIDS cases.

Two new objectives have been added. One seeks to increase the number of worksites that implement a comprehensive HIV/AIDS workplace program in large and small businesses as well as in the Federal Government. A second new objective seeks to increase the linkages between primary care and substance abuse clinics.

A shared objective 5.5 on adolescent abstinence from sexual intercourse has been added from the Family Planning priority area.

Other revisions include the tracking of objective 18.1 according to AIDS case rates per 100,000 population rather than the number of cases by year of diagnosis. While the revised measure will continue to reflect some of the tracking problems mentioned earlier, CDC now estimates the incidence of AIDS opportunistic illnesses (including HIV dementia and wasting syndrome) by year of diagnosis to make trend analysis more consistent. The target for objective 18.2 has been revised to confine the prevalence of HIV infection to no more than 400 cases per 100,000 people. At the time this objective was originally drafted it was believed that the epidemic was going to expand at a faster rate. The target for objective 18.6 was increased to strive for a higher percentage of injecting drug users who use only new or properly decontaminated drug paraphernalia. For objective 18.8, the measure will track the percentage of positive tests for which people return for counseling, as compared with those who have only been tested. Language in 18.10 seeks to clarify that the content of HIV and STD education curricula should be scientific and address prevention and disease transmission. For objective 18.11, the measure is shifted from the percentage of colleges that offer HIV education to the proportion of students who received HIV and STD education.

Sexually Transmitted Diseases



Lead Agency: *Centers for Disease Control and Prevention*

SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases (STDs) disproportionately affect the young, the poor, and minorities. STDs have serious health effects and can lead to impaired fertility, ectopic pregnancies, and other adverse pregnancy outcomes such as low birthweight and prematurity. Chronic pain, cervical cancer, and chronic liver disease also are the potential consequences of sexually transmitted infections. STDs and HIV infection are linked not only by common underlying risk behaviors but also by biological mechanisms. The presence of STDs has been documented as increasing the transmission and acquisition of HIV infection.

The burden and suffering from STDs make prevention of the estimated 12 million cases that occur each year in the United States imperative. Two-thirds of the STD cases occur among young people under the age of 25 years, and STD infection rates are higher in the southern States (see State map). Both statistics show the opportunity and challenge of shaping effective STD prevention strategies. Different approaches in different communities are needed, and in all instances must be shaped by the people at risk and those who are infected.

Population-based, community-wide efforts of State and local health departments are the first line of defense against STDs. Public sector programs often are the preferred provider of STD services because they can offer confidentiality. However, the public sector cannot possibly combat STD infections alone. STD prevention must be integrated into the health care practice of private sector primary care providers. This service can be facilitated through sharing information from the public sector's surveillance and laboratory systems. Developing a community's capacity for rapid response to STD outbreaks and effective partner notification programs will help prevent STDs.

Public education about the risk and the spread of disease is important. Rather than stigmatize people with fear, effective prevention messages stress positive and esteem-enhancing imagery such as "take care of yourself, you are worth it." School health programs are educating adolescents about healthy behaviors and adopting a lifestyle at an early age to minimize risk of STD infections. STD and HIV prevention services are being combined, as are STD services and reproductive health care in family planning clinics to strengthen behavioral interventions in the most at-risk communities. STD program linkages with substance abuse prevention programs enable street and community outreach workers to get important information and services to people who do not seek care in traditional health care settings.

Health department and university collaborations are being supported through the National Institutes of Health (NIH)-funded STD Cooperative Research Centers and the Centers for Disease Control and Prevention (CDC) STD Accelerated Prevention Campaign grant program. Through the NIH, CDC, World Health Organization, and U.S. Agency for International Development, work is underway to develop new and

inexpensive rapid STD diagnostic tests. Together biomedical and behavioral research can provide a strong science base to support effective STD prevention.

Review of Progress

At an October 1994 HEALTHY PEOPLE 2000 progress review with the Assistant Secretary for Health there was both good and bad news. Nearly all STD rates are on the decline, including gonorrhea, repeat gonorrhea infection, primary and secondary syphilis, and congenital syphilis. Pelvic inflammatory disease (PID) and sexually transmitted Hepatitis B also show progress toward the year 2000 targets. Among special population groups the rates of decline are not as great. The challenge over the remaining 5 years of the decade will be narrowing the gap between the total population and reducing rates of STD infections among adolescents and certain racial and ethnic minority groups.

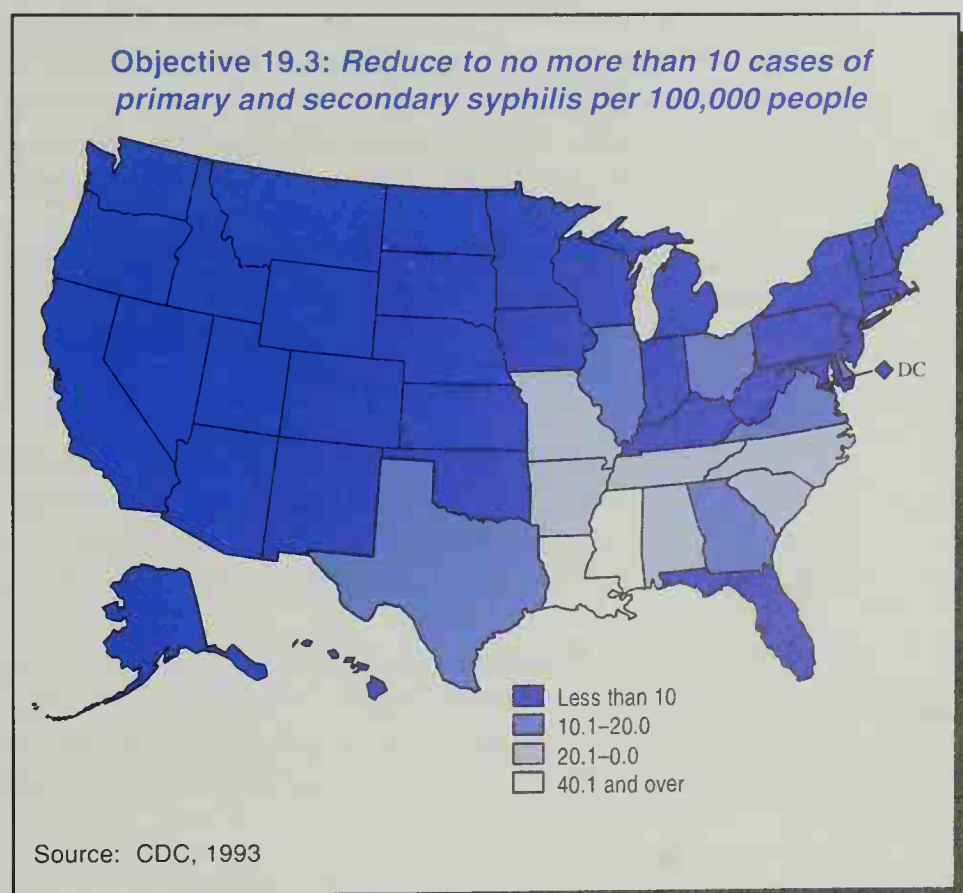
One objective moving away from the year 2000 target is the number of adolescents engaging in sexual intercourse. Among 15- and 17-year-old males and females, sexual activity has increased. At the same time, the percent of sexually active teens who report using a condom at last sexual intercourse has risen.

Baseline data for objective 19.14 show that clinicians do not routinely inquire about sexual practices of adolescents and adults. They provide counseling on STD and HIV prevention more routinely. Nurse practitioners reported that they routinely inquired about sexual practices of 52 percent of their patients and routinely counseled 50 percent about HIV and STD infections. For the other services and protection objectives, 19.11, 19.12, 19.13, and 19.15, there are no tracking data beyond the baseline.

1995 Revisions

Because of the success in preventing STDs, many of the year 2000 targets have been met at the midpoint of the decade. The targets have been made more challenging for reducing gonorrhea, primary and secondary syphilis, congenital syphilis, and pelvic inflammatory disease.

In 1988 chlamydia infection was difficult to document because of the



limited use and expense of diagnostic methods (culture). At that time, a nonspecific surrogate marker, nongonococcal urethritis, was used to monitor trends in *Chlamydia trachomatis*. Dramatic changes in diagnostic technology in the past few years have resulted in wide-scale screening for chlamydia infection in medical practice throughout the country. For this reason objective 19.2 has been revised to be a direct measurement of chlamydia infection. As screening for chlamydia becomes more and more common, especially among women, most of the infections detected will be among asymptomatic women and will represent predominantly prevalent disease. Monitoring this condition is problematic if only the number of infections detected is counted because as screening increases, so will the number of cases detected. Screening demonstration projects have suggested that a more meaningful measurement of the reduction in chlamydia infection is the proportion of women who screen positive over time.

In 1992 data became available for the first time to monitor repeat gonorrhea infection by race/ethnicity. These data were collected in 26 sentinel STD clinics throughout the United States as part of the Gonococcal Isolate Surveillance Project. Abstractors reviewed the medical charts of male patients with confirmed gonorrhea infection to determine whether any other episodes of gonorrhea were recorded for the patient within the previous 12 months. These data show that blacks have had a higher rate of repeat gonorrhea infection and support the establishment of a special population target for blacks for objective 19.8.

The baseline and target for objective 19.4 have been revised to reflect the 1988 change in definition for congenital syphilis. Many infants who would not have been counted in previous years now are included. Because the adoption and implementation of the new case definition by all States took 4 years, the 1990 data are regarded as most complete and now have become the baseline. In 1992 data became available to determine congenital syphilis incidence by race/ethnicity, allowing identification of population groups with disparate STD burdens. Based on these data, special population targets were established for blacks and Hispanics.

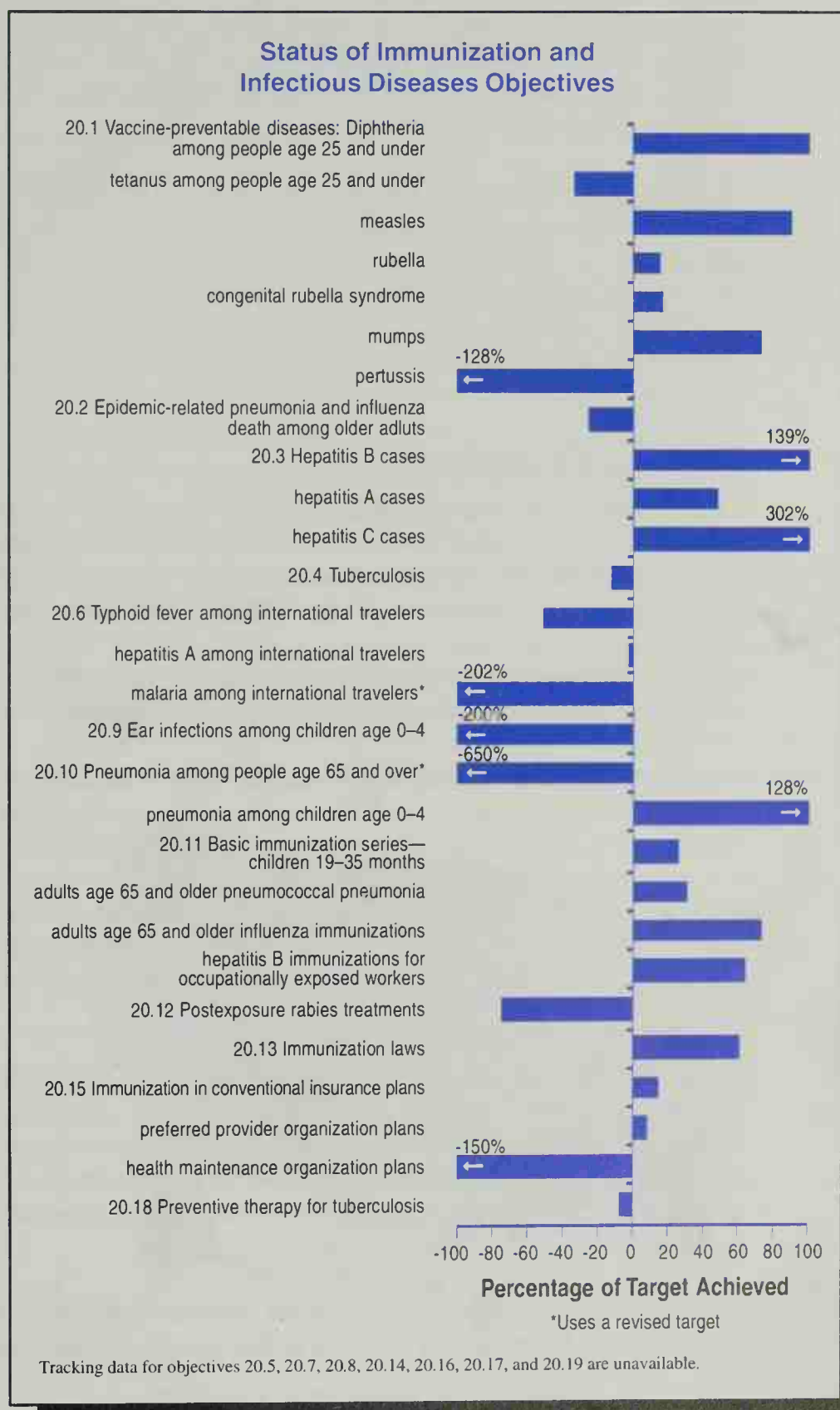
The baseline and target for objective 19.5 also have been revised. These adjustments are based on a new analysis and new weighting of the 1988 data. The original baselines were 167,000 (herpes) and 451,000 (warts); the new baselines are 163,000 (herpes) and 290,000 (warts) for 1988.

PID hospitalizations per 100,000 women aged 15–44 in 1991 surpassed the year 2000 target. To some extent this decrease may be the result of changes in medical practice as well as a decline in disease incidence. A more challenging target for reducing PID hospitalizations has been established for the year 2000.

Data from the 1988 National Hospital Discharge Survey suggest substantive differences in the rates of hospitalizations for PID between white and black women. Adolescents also were found to have some of the highest rates of acute gonorrhea and chlamydia and have higher rates of hospitalization for PID than the general

population. Special population targets have been established in objective 19.6 for blacks and adolescents (ages 15–19).

STD epidemiologic trends suggest that chlamydia is likely to be the cause of an increasing proportion of PID in U.S. women. Because the severity of chlamydia PID appears to be less on average than that from gonorrhea, a significant number of women with PID in the 1990s are likely to be treated as outpatients. Objective 19.6 has been expanded to track and reduce outpatient visits for PID.



IMMUNIZATION AND INFECTIOUS DISEASES

The availability of vaccines and antibiotics, improved hygiene, regulations for food handling, and treated water supplies have led to tremendous inroads in preventing and controlling infectious disease. Constant surveillance and monitoring are necessary to control new, reemerging, and drug-resistant infectious agents currently causing illness and death in the United States. New infectious diseases such as Lyme disease, diarrhea caused by *Escherichia coli* 0157:H7, hantavirus pulmonary syndrome, and the large number of diseases associated with HIV infection continue to be major threats to public health.

The 19 objectives in priority area 20 set targets to decrease the number of cases of vaccine preventable diseases, viral hepatitis, and pneumonia and influenza deaths, and to reduce tuberculosis cases, surgical and nosocomial infections, illness among international travelers, bacterial meningitis, diarrhea in child care centers, and ear infections in children. The priority area also sets targets to increase the number of children and adults who are appropriately immunized and the number of States requiring immunizations.

Review of Progress

As of January 1995, substantial progress has been made in achieving the year 2000 objectives in this priority area. During 1993 and 1994 (provisional data), the number of cases of diphtheria, poliomyelitis due to wild virus, measles, mumps, and rubella had all decreased from the baselines. Although data are not available to assess progress against all causes of bacterial meningitis, the decline of *Haemophilus influenza* meningitis by over 95 percent since introduction of the new conjugate Hib vaccines in children suggests substantial progress toward the year 2000 target.

The U.S. map shows that 21 States and the District of Columbia had no measles cases in 1993. Eight States had 10 or more cases; no State had more than 100 cases. During 1994, reported measles cases increased but remained the second lowest total ever recorded. The international importation of an average of one measles case each week will continue to result in the spread of measles in the United States until improved coverage is achieved and sustained with the measles, mumps, and rubella (MMR) dose in preschool children and a second MMR dose in school- and college-age children.

In contrast, disease incidence for pertussis reached a 25-year high in 1993 (6,586 cases). But in 1994 pertussis cases decreased by 40 percent to 3,590 cases. Sustaining decreases in pertussis incidence will require that acellular pertussis vaccines are introduced for infants, with booster doses for adolescents and adults. Tetanus in people aged 25 years and younger has shown a slight increase, with 36 cases reported in 1994.

In 1992 the overall immunization rate of children aged 19–35 months was 55 percent; in 1993, 67 percent of children in this age group had received four diphtheria,

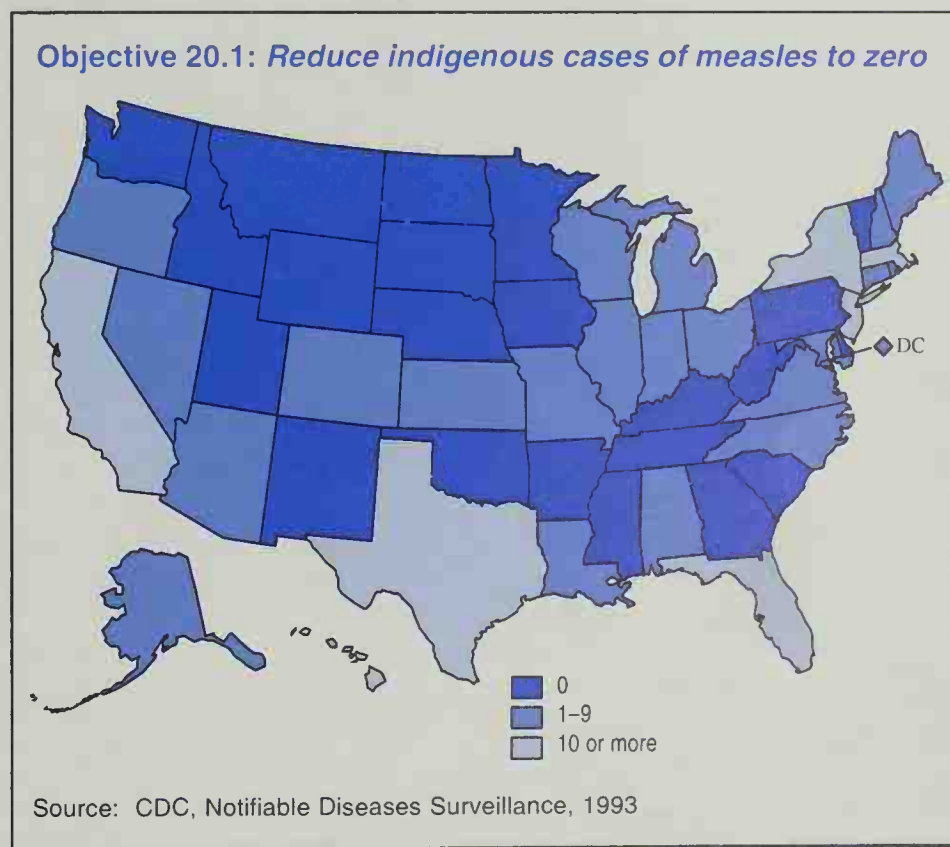
tetanus, and pertussis (DTP) doses, three polio vaccine doses, and one measles containing vaccine. Full immunization levels can be aided by extension of State laws requiring immunization of children not only in schools but also in preschools and child care settings. In addition, insurance coverage of immunizations can facilitate receipt of vaccines.

Immunization levels for pneumococcal pneumonia and influenza among adults 65 and older have increased. In 1993, 52 percent of older adults had received an influenza vaccination, and 28 percent had received a pneumococcal vaccination. However, epidemic-related pneumonia and influenza deaths among older adults continue to be substantial (estimated 50,000 to 70,000 deaths annually). Hepatitis A, B, and C have decreased. All the special population targets under hepatitis B are moving in the direction of the target. Hepatitis A among international travelers has decreased, but malaria and typhoid have increased. The increase in malaria may be attributable to an increase in the number of Americans traveling to areas with malaria, the increasing number of foreigners entering the United States, and the spread of antimalarial drug resistance.

Several factors have inhibited progress toward reducing ear infections in children, including the increased number of children in child care settings and the emergence of antimicrobial resistance. Outpatient office visits and the number of restricted activity days for otitis media in young children have increased. The development and evaluation of a new pneumococcal conjugate vaccine, and the identification of risk factors for infection could lead to new prevention strategies.

The rise in tuberculosis rates—particularly among Asians/Pacific Islanders, blacks, and Hispanics—requires that efforts be redoubled for people already infected. The number who complete therapy to prevent the spread of the disease is moving away from the target.

Since the publication of *Healthy People 2000*, baselines have been established for objectives 20.5, 20.8, 20.14, 20.16, and 20.19. For many of these objectives, meeting the year 2000 targets poses great challenge.

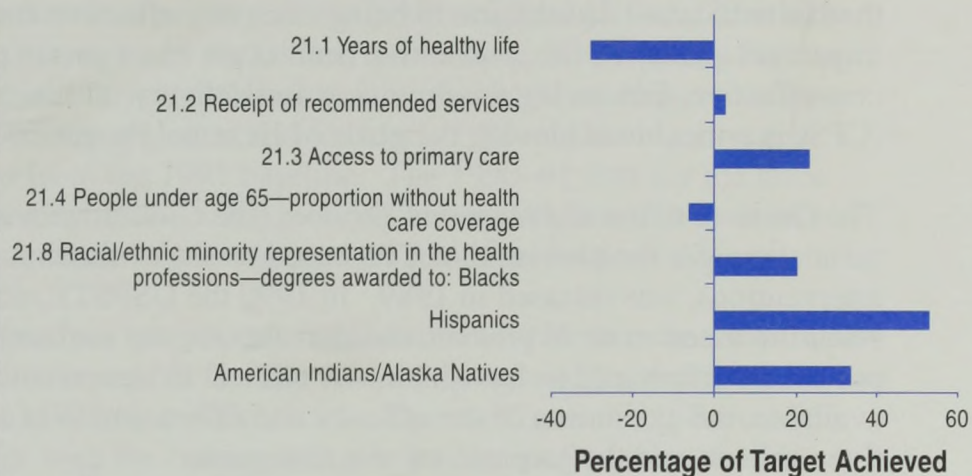


1995 Revisions

A number of baselines have been revised, necessitating target revisions for objectives 20.2, 20.3, 20.6, 20.9–20.11, and 20.13. Black and Hispanic subobjectives have been added to 20.3 tracking hepatitis, and to objective 20.11, adult immunizations. Another revision is to track childhood immunizations through age 2 (19–35 months) rather than by age 2 (24 months).

Clinical Preventive Services

Status of Clinical Preventive Services Objectives



Tracking data for objectives 21.5-21.7 are unavailable.

Lead Agencies: *Health Resources and Services Administration*
Centers for Disease Control and Prevention

CLINICAL PREVENTIVE SERVICES

Since the U.S. Preventive Services Task Force (USPSTF) was convened in 1984, national attention has been focused increasingly on the importance and effectiveness of preventive services in clinical settings in improving the Nation's health. Evidence continues to mount that immunizations, screening tests for early detection of disease, chemoprophylaxis, and patient education and counseling to improve health-related behaviors can reduce the incidence of the leading causes of disease and disability in the United States. In addition to being clinically effective and having a positive impact on quality of life, preventive health care has a strong probability of being cost-effective. Enhancing the provision and delivery of clinical preventive services (CPS) is critical to achieving the goals of HEALTHY PEOPLE 2000.

The *Guide to Clinical Preventive Services* (the *Guide*), with comprehensive recommendations for the provision of CPS based on the evaluation of 169 preventive interventions, was released in 1989. In 1990 the USPSTF reconvened to continue its scientific assessment of preventive interventions, the reexamination of established preventive interventions for which new clinical evidence/outcomes measures become available, the evaluation of the efficacy and effectiveness of less-researched preventive services, and the preparation of a new guide.

The *Guide* and implementation strategies that followed address this fact: many primary care providers do not deliver important CPS—such as immunizations, pneumococcal vaccine for elderly people, clinical breast examination, and counseling on high-risk behaviors—at the recommended intervals. Studies indicate provider uncertainty about services and intervals, skepticism about the efficacy of some CPS, disagreement on methodology, lack of reimbursement, and outdated or missing clinical information on the effectiveness of CPS. Since 1990, new empirical data, along with information provided by the *Guide*, have led the Public Health Service (PHS), numerous national-level provider organizations, and a growing number of health-related associations to endorse the routine inclusion of CPS in periodic health examinations and the reimbursement for preventive services as part of a basic package of insurance benefits. Since 1993, payment to providers for the provision of preventive services has increased as Federal agencies have collaborated to update and assign processing codes to preventive services—a prerequisite to filing reimbursement claims with private and public insurers.

In August 1994 the PHS announced the national campaign Put Prevention Into Practice (PIIP), a Federal strategy developed to promote the delivery of CPS by primary care providers and to achieve the goals of HEALTHY PEOPLE 2000. A partnership between the public and private sectors, PIIP is a research-based approach featuring a kit with implementation and educational materials. The dissemination of PIIP in clinical and health professions training settings has been increasing, and the initiative is being adopted for use by a growing number of national-level managed care plans.

The *Guide*, PPIP, and the National Coordinating Committee on Clinical Preventive Services together support the implementation of strategies to achieve the CPS objectives in HEALTHY PEOPLE 2000. With States, communities, primary care providers, and payor organizations, the PHS is working to encourage a shift to preventive health care.

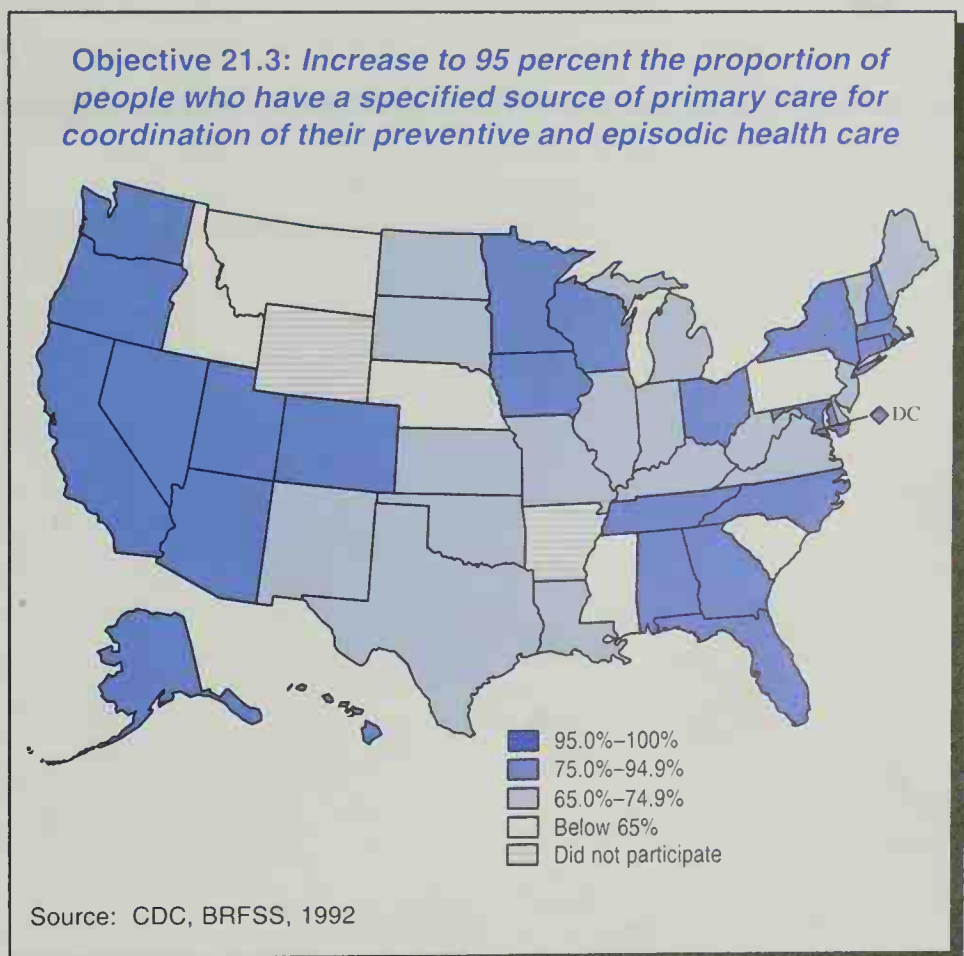
Review of Progress

The Clinical Preventive Services priority area contains eight objectives. For those objectives for which progress can be measured, results have been mixed. For example, for the objective on the years of healthy life, data indicate movement away from the targets for the total population and for blacks. People having a routine source of care increased from the 1991 baseline. The 1990–91 data for the three minority groups (Hispanics, blacks, and American Indians/Alaska Natives) show improvements in representation of these groups in health professions degrees.

Baseline data for all objectives have been established, and followup data sources are available for all objectives except 21.5. The co-lead agencies, Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC), continue to work with the National Center for Health Statistics to address data issues. Improved data comparability and better data for special population groups are needed to assess progress in CPS. A key focus of HRSA and CDC's efforts has been to expand national-level surveys and to identify other data sources that could be modified or used to track progress on the CPS objectives. Since 1993, more data have been provided by expansion of the National Health Interview Survey.

1995 Revisions

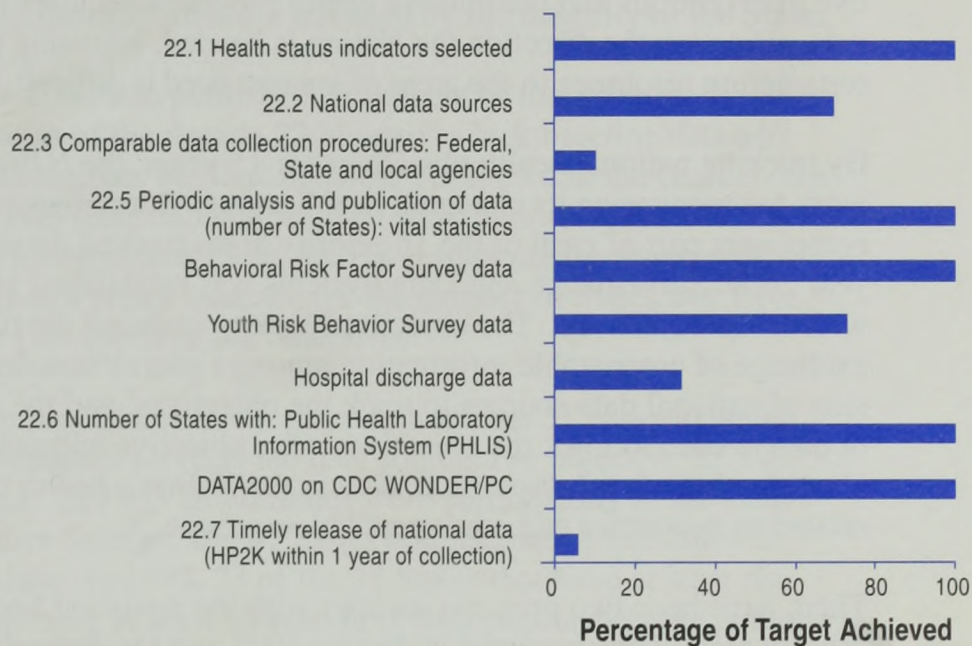
For the Midcourse Review special population targets were added to objectives 21.3 and 21.4. Objective 21.2 was expanded to show the receipt of a range of individual rather than aggregated clinical preventive services received by population groups. To better target strategies, special population targets were organized by the individual clinical preventive



Healthy People 2000 Midcourse Review and 1995 Revisions

services as well as by age, gender, and special population groups (when there was at least a 10 percent disparity with the total population). A new subobjective was added to 21.8 to track the entry of underrepresented racial and ethnic minority groups into U.S. schools of nursing.

Status of Surveillance and Data Systems Objectives



Tracking data for objective 22.4 are unavailable.

Lead Agency: *Centers for Disease Control and Prevention*

SURVEILLANCE AND DATA SYSTEMS

Surveillance and data systems provide the foundation for the HEALTHY PEOPLE 2000 objectives process. In fact, measurability was one of the principal criteria for setting objectives in 1990. Having baseline data and ongoing data sources was critical in establishing starting points when *Healthy People 2000* was published and where the Nation is heading at mid-decade. The ability to assess health status, health disparities, or service needs or to evaluate the implementation and effectiveness of preventive interventions and community health programs requires information. Without data indicating the direction the Nation is headed, adjusting programs and strategies or targeting resources to the areas of greatest need is difficult.

By tracking national health objectives for 15 years, the Nation has created a framework for monitoring its changing health status. Surveillance and evaluation was a component part of each of the 15 priority areas tracked during the 1990s. For the year 2000, Surveillance and Data Systems was established as its own priority area with seven objectives. The objectives seek to improve the timeliness of data, the exchange of comparable information among Federal/State/local agencies, the expansion of national data sources to track the objectives, and the analysis and publication of data needed to track the objectives. One objective addresses improvements in the identification of and response to data in the Nation's health data, including data related to minorities and other population groups.

There have been two progress reviews with the Assistant Secretary for Health for this priority area. They occurred in August 1991 and December 1992.

To enhance State capacity to assess progress toward HEALTHY PEOPLE 2000 objectives, the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) in 1992 awarded 5-year grants to Iowa, Maine, North Carolina, Ohio, Oregon, Texas, and Utah. These grants are to improve State capacity to provide data for HEALTHY PEOPLE 2000 objectives by updating data systems and enhancing data analysis. Kansas also is participating in this data improvement initiative through the support of the Kansas Health Foundation.

Review of Progress

As of June 1995, 42 States, the District of Columbia, and Guam had developed year 2000 plans. All other States have undertaken assessments related to the year 2000 objectives. An analysis of these year 2000 plans shows that 31 States had surveillance and data systems objectives. Another 4 States and the District of Columbia identified data needs in their State plans.

A consensus set of 18 health status indicators was released by CDC/NCHS in 1991. Nine mortality indicators (infant mortality, total deaths, motor vehicle crash deaths, work-related injury deaths, suicides, homicides, lung cancer deaths, female breast cancer deaths, and cardiovascular disease deaths) are included among the consensus indicators. Four indicators of infectious diseases (AIDS, measles, tuberculosis, and

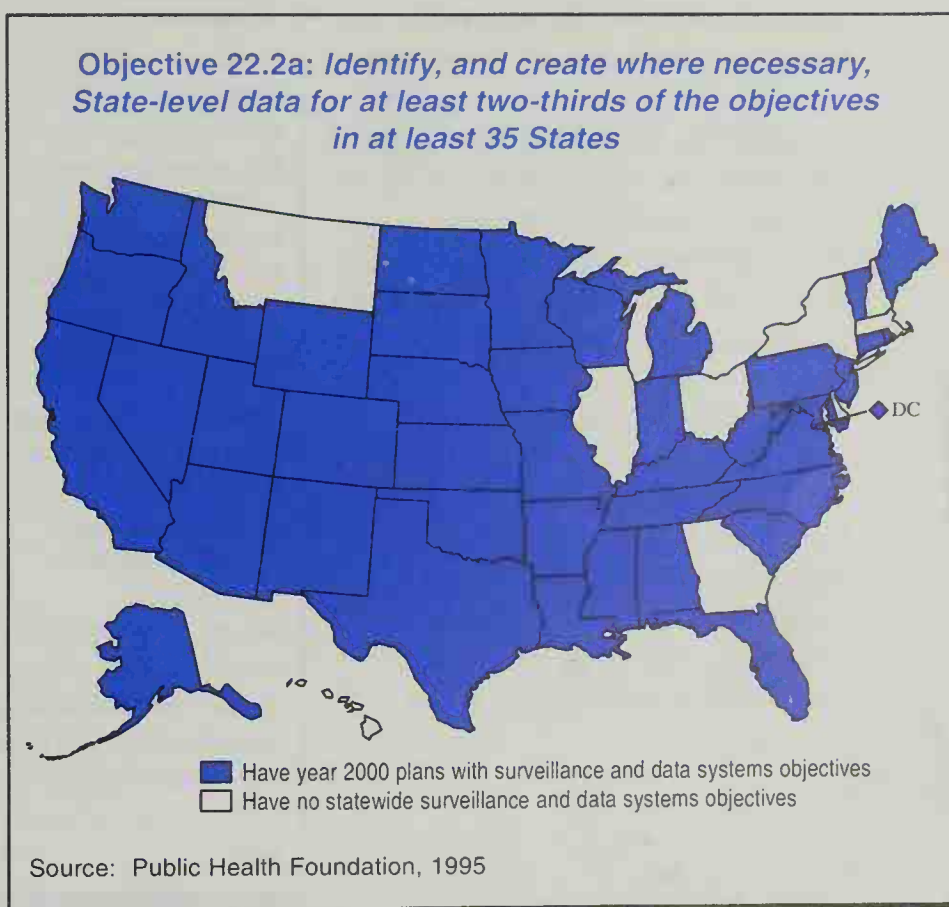
syphilis) are used. Three indicators of health status are related to maternal and infant health—prevalence of low birth weight, number of births to adolescents, and percentage of mothers delivering live infants who did not receive first trimester prenatal care. Childhood poverty and the proportion of people living in counties exceeding air quality standards complete the list of consensus indicators. A 1992 survey conducted by the University of Pittsburgh researchers and published in the *American Journal of Public Health* in October 1994 found “widespread” use of the consensus indicators among the States, with nearly all of the States using all of the indicators. The air quality measure was the only measure not used by the majority of the States.

At the time *Healthy People 2000* was published 77 percent of the 300 objectives had baseline data. At the midpoint of the decade 23 objectives lack baseline data and another 63 objectives have baselines but lack updates. As shown in the chart on the following page, 107 objectives have annual data, 202 have periodic data, and 28 need new data sources. As for objective 22.2a, NCHS is tracking the number of States with year 2000 plans as a proxy measure for the number of States that have State-level data for at least two-thirds of the objectives.

Comparable data collection procedures are in place to track the 51 national health objectives for which vital statistics serve as the data source. For objective 22.5 all 50 States publish vital statistics. In 1993 all 50 States were participating in the Behavioral Risk Factor Surveillance System, and 39 States had legislative mandates to collect hospital discharge data. In 1993, 23 of the 27 States that have at least one racial or ethnic group comprising at least 10 percent of their population were publishing vital statistics data on racial and ethnic groups.

Procedures for collecting comparable data continue to be developed. The number of States with the ability to transfer data among Federal, State, and local agencies has increased. The National Electronic Telecommunications System for Surveillance, the Public Health Laboratory Information System, and DATA 2000 on CDC WONDER/PC are now present in all States.

The baseline established for objective 22.7 shows timely data release. As



Healthy People 2000 Midcourse Review and 1995 Revisions

of February 1994, data were released within 1 year of data collection for 67 percent of the objectives, and an additional 24 percent of the objectives had data published between 1 and 2 years of collection.

For objective 22.4, a process measure, the midcourse review has provided an opportunity for the identification of data gaps. Discussions are ongoing about developing new data sources for tracking the objectives.

Because resources for information systems are constrained at the Federal/State/local levels, one of the challenges throughout the remainder of the decade will be to maintain current tracking capability and expand this capability to cover objectives for which there are currently no data or proxy measures. Another challenge will be determining new and representative ways of tracking the objectives targeted to racial and ethnic minorities, low-income people, and people with disabilities. A priority will be filling data gaps so that at the end of the decade the Nation knows whether progress has been made or whether there has been failure in achieving the year 2000 targets.

1995 Revisions

Revisions have been made to two objectives in this priority area. The intent of subobjective 22.2a, "identify and create where necessary State-level data for at least two-thirds of the objectives in at least 35 States," has been clarified to "identify and create where necessary State-level data sources to monitor at least two thirds of the objectives contained in State Year 2000 plans." The revisions to subobjective 22.5a are "to implement in at least 25 States periodic analysis and publication of data needed to measure State progress toward the national or State-specific health objectives for each racial or ethnic group that makes up at least 10 percent of the State population." These revisions have been made to ensure that the intent of the data objectives is supporting States in their efforts to track their own objectives and to contribute to the national effort.

Priority Area	Number of Objectives With:		
	Annual Data	Periodic Data	New Source Needed
Physical Activity and Fitness	1	10	1
Nutrition	4	16	1
Tobacco	5	10	1
Substance Abuse: Alcohol and Other Drugs	11	5	3
Family Planning	0	9	2
Mental Health and Mental Disorders	1	12	1
Violent and Abusive Behavior	5	7	6
Educational and Community-Based Programs	2	0	2
Unintentional Injuries	14	3	5
Occupational Safety and Health	7	8	0
Environmental Health	4	11	1
Food and Drug Safety	2	4	0
Oral Health	1	15	0
Maternal and Infant Health	9	6	1
Heart Disease and Stroke	4	13	0
Cancer	7	9	0
Diabetes and Chronic Disabling Conditions	8	10	2
HIV Infection	1	12	1
Sexually Transmitted Diseases	7	8	0
Immunization and Infectious Diseases	7	11	1
Clinical Preventive Services	2	6	0
Surveillance and Data Systems	1	6	0
Age-Related Objectives	4	1	0
Total	107	202	28

CHAPTER 3

Consortium Action

State HEALTHY PEOPLE 2000 Activities

**Private and Voluntary Sector
HEALTHY PEOPLE 2000 Activities**

STATE ACTION FOR HEALTHY PEOPLE 2000 MIDCOURSE REVIEW

Introduction

Achieving the objectives set forth in *Healthy People 2000* will require a coordinated commitment by Federal, State, and local governments as well as the private and voluntary sectors. While the Federal government has responsibility for coordinating and monitoring the overall effort to meet the national objectives, State and territorial health agencies (hereafter referred to as States) have embraced the concept of public health management by objectives and organized statewide efforts to meet and measure those objectives. Today, most States have developed their own disease prevention and health promotion objectives, many using *Healthy People 2000* as a guide.

This section of the Midcourse Review provides an overview of States' objective-setting and implementation activities. It represents an effort to showcase the interstate network of disease prevention and health promotion activities related to HEALTHY PEOPLE 2000. It presents both the commonalities and differences among States in the processes they used to develop their objectives as well as the strategies and activities they are pursuing to achieve those objectives. Finally, it highlights the specific successes and challenges of individual States as they strive to fulfill their disease prevention and health promotion agendas.

Project Objectives

This section of the report presents the results of a collaborative project of the Office of Disease Prevention and Health Promotion and Public Health Foundation (PHF) to learn about States' efforts to establish statewide health objectives; integrate those objectives into their health planning and policy development; and carry out programs, interventions, and other activities to meet the objectives. The specific objectives of this project are to:

- Provide a national snapshot of how States are working toward achievement of health objectives.
- Serve as a catalyst for the exchange of ideas and successful strategies and to encourage States' future commitment to achieving the objectives.

This summary of States' action pertaining to HEALTHY PEOPLE 2000 is not intended to show a comprehensive picture of States' implementation activities, but rather to provide a synopsis of States' activities as well as selected examples of innovative uses of objectives and approaches to achieving them.

The summary is organized into three parts. The first part highlights States' objective-setting activities, including the extent to which State objectives mirror the national objectives. The second part illustrates the activities undertaken by States to meet the objectives. The final part features States' efforts to track and monitor

progress toward meeting the objectives. The Public Health Service (PHS) hopes this information will be used by States to learn from other States about the myriad ways in which difficult disease prevention and health promotion issues can be addressed.

STATES' OBJECTIVE-SETTING ACTIVITIES

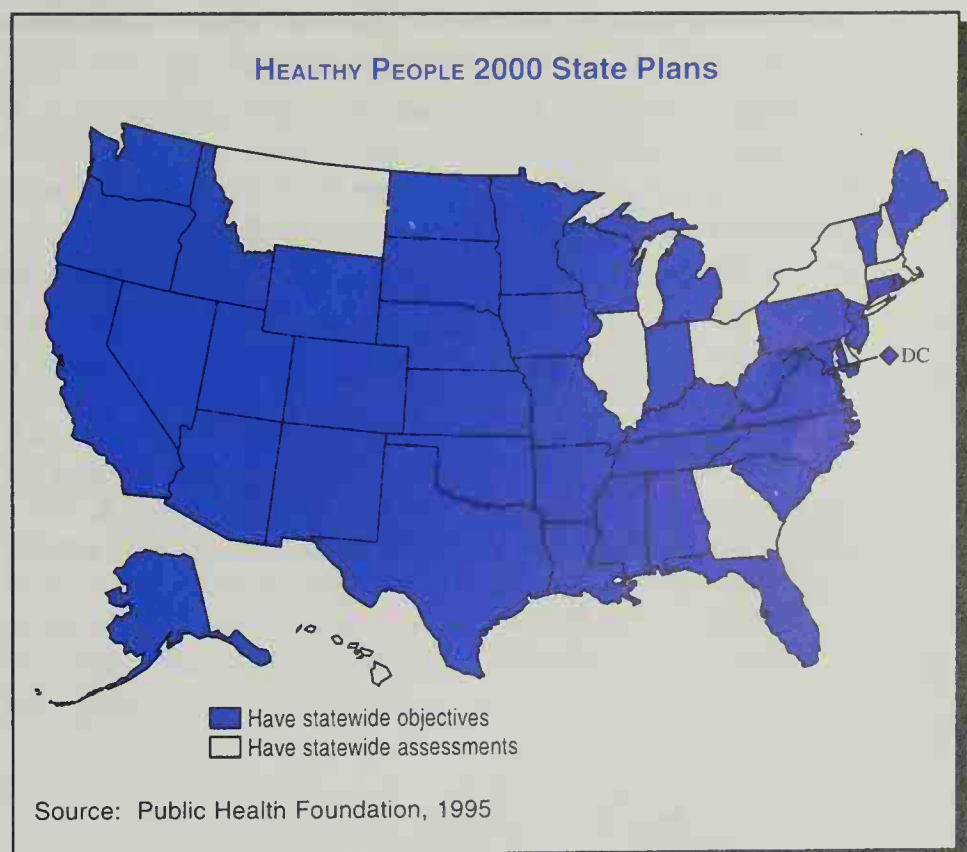
Most States have committed to developing and achieving State-specific health promotion and disease prevention objectives. As of March 1995, 42 States, the District of Columbia, and Guam had statewide health objectives. An additional 8 States have undertaken year 2000 assessments, measuring their populations' health against the national objectives. The status of States' objective-setting process is shown on the map below.

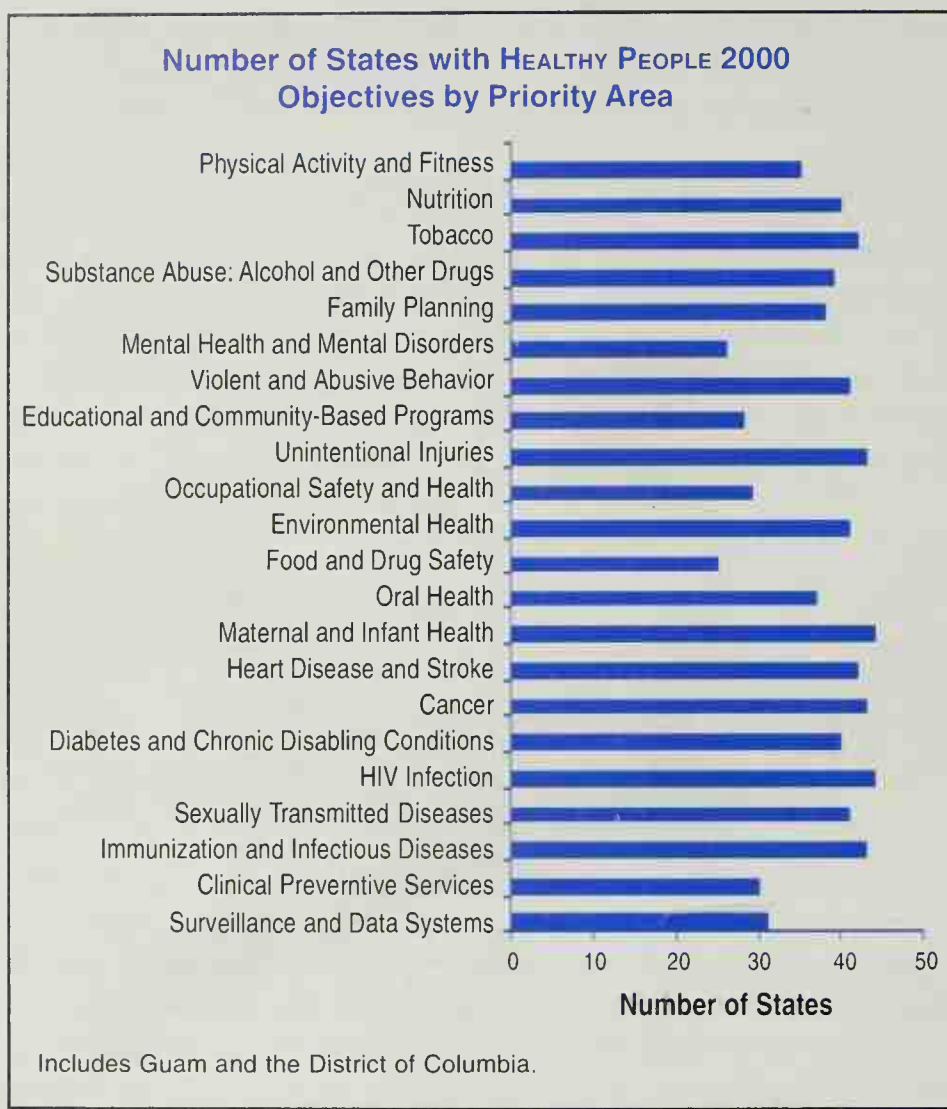
Priority Areas Covered By State Objectives

Overall States' coverage of the HEALTHY PEOPLE 2000 priority areas in their objectives is extensive. Previous information-gathering efforts by PHS and PHF indicate that many States used the HEALTHY PEOPLE 2000 objectives as a guide in establishing their own State-specific objectives.¹ In addition to using national targets as a starting point, some States indicated that they were able to build on previously established programs or department-wide objectives in setting their State-specific objectives.

Each of the 22 HEALTHY PEOPLE 2000 priority areas is being addressed by at least 25 of the States. For two priority areas—maternal and infant health and HIV infection—42 States, the District of Columbia, and Guam (hereafter the territories and the District of Columbia are included in the State totals) indicated that their objectives covered these areas. Other priority areas receiving extensive coverage include unintentional injuries (43 States), tobacco (42 States), heart disease and stroke (42 States), violence (41 States), environmental health (41 States), sexually transmitted diseases (41 States), nutrition (40 States), diabetes (40 States), alcohol and other drugs (39 States), and family planning (38 States).

Fewer States identified surveillance and data systems (31 States), clinical preventive services (30 States),





occupational safety and health (29 States), educational and community-based programs (28 States), mental health and mental disorders (26 States), and food and drug safety (25 States).

Because this information-gathering effort focused mainly on implementation activities, rather than objectives-development, PHF did not ascertain the extent to which States excluded priority areas

that may have been indirectly addressed through other priority areas. However, information provided in previous years showed that most States' objectives directly or indirectly addressed most of the priority areas identified in *Healthy People 2000*.² For example, a State that might not have reported nutrition as a priority area could be addressing nutrition-related objectives within its maternal and infant health, environmental health, cancer, or cardiovascular disease areas. Similarly, tobacco objectives are sometimes included under maternal and infant health, heart disease and stroke, or cancer priority areas.

Many States selected additional priority areas that were not included in the HEALTHY PEOPLE 2000 objectives, reflecting their intent to address their populations' most pressing health problems. These included minority health, access to health services, emergency medical services, cost containment, rural health, and children with special health care needs.

Forming Partnerships to Develop Objectives

Similar to the national collaborative process employed by PHS to set the HEALTHY PEOPLE 2000 objectives, many States involved a wide range of individuals and organizations in their objectives-setting process. Through State and local coalitions, multidisciplinary planning and advisory groups, and program area-specific task forces, States engaged representatives from both the public and private sectors to establish their statewide objectives. In general, participants represented State and local health and human services organizations, other State and local government agencies, health insurance plans, academic institutions, professional associations, private and voluntary community organizations, health care professions, local and statewide coalitions, consumer and citizen groups, local businesses, and State legislatures.

For many States, the objectives-setting process resulted in not only improved coordination within the health department, but also constituency-building across the State, engaging agencies and organizations other than the State health agency in the process. Motivating these agencies to take ownership of, and commit to, these objectives is essential since the actions of these other agencies and organizations will ultimately determine whether a State achieves its objectives. States described an array of benefits resulting from coalition-building and collaboration with outside agencies to identify year 2000 objectives. Examples of such benefits include:

- Common vocabulary for disease prevention and health promotion.
- Increased visibility and awareness of the importance of disease prevention and health promotion activities.
- Focus for media and health education efforts.
- Framework or stronger position for developing and supporting legislation.
- Mechanism to increase communication and program coordination within the department.

In addition to garnering input and support from outside agencies and organizations, a number of States attempted to empower the general public in their objectives-development process through such mechanisms as focus groups, public hearings, and draft review periods. New Jersey even conducted an independent public opinion poll to gauge public reaction and support.

Basing Objectives on Sound Data and Information

Many States cited the important role that data and information played in the development of their objectives. States used baseline and trends data on the leading causes of death, pressing health problems, and the availability of effective interventions in establishing their objectives. Many States also based their selection of objectives on the availability of sound data to track progress.

Hawaii's strategy is a good example of using data to establish objectives. Hawaii created a "baseline" of data that health department programs could use with existing coalitions to develop a draft set of objectives. The *Healthy Hawaii 2000* project selected three to five health status indicators for each of Hawaii's 19 priority areas and, using baseline data on these indicators, constructed statistical projections and forecasts for their proposed objectives. Still in the review process, Hawaii's state-wide objectives are expected to be formally adopted in 1995.

Under its Health Care Reform Act of 1992, Florida is required to develop a biennial plan that includes data on the health status of the population and contains specific health status objectives and outcome measures. Incorporated in its *Healthy Communities, Healthy People Plan*, Florida's health objectives focus on risk behaviors and community conditions that relate to the leading causes of death in the United States and Florida.

Establishing Health Objectives Oversight/ Coordinating Groups

In many cases, States formed an objectives oversight group or planning agency to coordinate the development and implementation of their objectives. Iowa and North Carolina established task forces out of the governor's office to steer the development of their disease prevention and health promotion objectives. As a result of the task force's recommendations in North Carolina, a state-level Office of Healthy Carolinians was created to assist county- and community-level coalitions in setting their goals and objectives.

As a result of its State health objectives process, Guam established a health planning agency responsible for comprehensive health planning for the territory. Guam designated 13 task forces and lead agencies, one for each of Guam's Territorial Health Goals, to plan, prepare, and develop measurable objectives for each goal and to monitor progress for each objective. In Arizona, the Department of Health Services created an advisory committee, the "Arizona 2000 Action Team," to work with the Office of Strategic Planning to incorporate Arizona's year 2000 objectives into the health department's 3-year strategic plan. The action team hired a full-time coordinator to manage the Arizona 2000 implementation process.

Additional Challenges and Problems

While many States cited the use of reliable data and information in establishing objectives as a highlight, the lack of such data was also frequently mentioned as a challenge or problem in the objectives-setting process. In Nebraska, for example, the lack of data for certain priority areas was a limiting factor in setting objectives. On the other hand, health officials there felt more comfortable with their final objectives, knowing they would be able to measure progress toward the objectives.

Several other States described gaps in data as a limiting factor in setting health objectives. *Healthy Hawaii 2000* staff cited as inhibiting factors methodological problems in the coding of data, such as ethnicity data, and the lack of consistent denominators for specific population groups across surveys. Although North Carolina's data collection on the whole has been excellent, setting quantifiable goals for small areas in that State has been a problem. Data for areas within counties are either not available or not useful for tracking trends because of the inherent problems with small number instability.

Another challenge depicted by some States was to design public health programs that are outcome-oriented. Many of Nebraska's programs, for example, have objectives that are process-oriented and do not produce results that identify with the State health objectives. Officials in Nebraska are considering ways to improve this condition.

IMPLEMENTING THE OBJECTIVES

While most States indicated that their year 2000 objectives guided their public health activities, few had developed detailed implementation plans.³ However, States are engaged in a broad range of activities vis-à-vis their State health objectives. Although the information States provided on their implementation activities is diverse, it can be boiled down to several major themes: identification and resource allocation; policy development and strategic planning; program development and evaluation; legislative support and development; and community planning projects. An overview of States' implementation activities is presented below according to the aforementioned organizing themes. States' efforts to disseminate and promote their objectives and establish partnerships to achieve the objectives, as well as other challenges and problems they have faced, are also discussed.

Resource Identification and Allocation

A substantial number of the States indicated that their objectives serve as a basis for identifying and allocating new public health resources. In some cases, requests for Federal or State funding are closely tied to the objectives. For example, as a result of Maryland's priority and objectives-setting process, *Healthy Maryland 2000*, the legislature appropriated \$5 million to diagnose and treat needy Maryland women who may have cancer. Similarly, the Utah Department of Health secured a \$900,000 funding increase from Medicaid for the Tuberculosis Program to help meet Utah's HEALTHY PEOPLE 2000 tuberculosis goal.

Year 2000 plans or objectives also serve as a framework for setting department budgets and allocating programmatic resources. The Michigan Department of Public Health, for example, in keeping with its 2-year action plan for implementing *Healthy Michigan 2000*, is using revenues from a tobacco tax increase to fund expanded chronic disease prevention, violence prevention, immunization, and other program efforts.

Several States—including Alabama, Colorado, Kentucky, Maine, and Nebraska—said they are using their Prevention Block Grant to fund initiatives tied to their objectives. The Colorado Department of Health awards Prevention Block Grant funds to county health departments and nursing services for disease prevention and health promotion initiatives tied to the *Healthy Colorado 2000* objectives. Illinois used a portion of its Prevention Block Grant to fund the Illinois Project for Local Assessment of Needs (IPLAN) initiative, setting aside monies to implement the local needs assessment project. Funding was used to prepare the computerized data system for each of the 87 local health departments and to conduct training workshops for State and local agencies in data analysis and interpretation, priority setting, and strategic health planning. Some States indicated that they are beginning to require that local jurisdictions' requests for funding be directly tied to objectives. In Maine, for example, contracts to community agencies for public health services such as community-based cardiovascular disease prevention must be based on the objectives. Washington's health objectives, referred to in their *Public Health Improvement Plan* as "outcome standards," will be the basis for evaluating performance-based contracts between the Washington State Department of Health and its 33 local health jurisdictions.

State and local health officials in Arizona, Missouri, New Jersey, and Wyoming are identifying and categorizing the financial and programmatic resources that are currently being used to address their objectives. In general, these efforts will provide a basis for reallocating resources to priority areas.

Policy Development and Strategic Planning

Integrating statewide health objectives into strategic planning, policy development, or health care reform efforts was frequently cited as a State implementation activity. In general, States either have incorporated their objectives into their State plan, or their year 2000 objectives document serves as their State plan. The State of Oregon's involvement in development of its health objectives played a major role in leading to the Oregon Benchmarks project aimed at broad social progress in the State. In Louisiana, the Office of Public Health plans to issue a Request for Proposal to develop a strategic plan based on the State objectives. The strategic plan will provide a framework for collaborative relationships within the departments and other public and private agencies to improve the efficiency and effectiveness of the health services provided.

Missouri is also in the process of initiating statewide strategic planning into which it will build its Healthy People planning process. The goal is to further integrate the health department's planning activities with those of other State agencies in order to form a more effective policy development process for State government.

Several States described how their health objectives are an integral part of health reform efforts in the State. For example, Tennessee officials noted that the implementation of TennCare, their Medicaid managed care program, is based, in part, on their State objectives. Minnesota officials described as a major focus their work on a

report to the State legislature proposing recommendations for preserving and strengthening public health activities in light of health reform activities. Likewise, Florida, Maine, Rhode Island, and Utah mentioned health care reform efforts that included health objectives.

Program Development and Evaluation

The most frequent implementation activity was the development of programs, initiatives, and interventions to address the high priorities identified through the objectives process. States reported a myriad of new programs and initiatives resulting from their statewide objectives process, ranging from innovative programs, like the Rhode Island Department of Health's program offering door-to-door smoke detector installations in low-income neighborhoods, to more traditional programs, such as Delaware's Vaccines for Children program.

Several States (including Iowa, Michigan, and Missouri) indicated they had developed action plans for implementing their objectives and described how their objectives became an integral part of their everyday planning and program management. The Missouri Department of Health is working to establish their objectives as management tools, hoping to integrate them into their management processes. Iowa officials indicated that *Healthy Iowans 2000* was viewed by many in the health department as an opportunity to improve their planning and networks.

States credited their health objectives as the impetus for a variety of specific initiatives. Below are just a few examples illustrating the diversity of initiatives launched by States:

- Alabama: Established a division in the State Health Department to serve as a focal point for cancer prevention activities and is planning to implement a cancer registry.
- Rhode Island: Provided technical assistance to small water systems on corrosion control and well head protection, and provided lower interest financing of water system improvements.
- Utah: Increased focus on contacting families and informing them of well-child visits in an effort to increase participation in the Child Health Evaluation and Care Program.
- Texas: *Healthy West Texans*, a radio show, features doctors who discuss health promotion issues and answer call-in questions from listeners.

In addition to describing program activities and initiatives, a number of States cited examples of specific successes, or outcomes, attributable to their health objectives-implementation activities. For example, Louisiana attributed a 31 percent decrease from 1993 to 1994 in its secondary syphilis rate to an extension of services from 31 to 52 of Louisiana's health parishes. This initiative was a direct result of Louisiana's HEALTHY PEOPLE 2000 process, in which it selected sexually transmitted diseases as a

priority area. Over that same time period, South Carolina increased its age-appropriate immunization rate for 2-year-olds from 62 percent to 82 percent, an accomplishment health officials credit to South Carolina's "No Shots, No School, No Day Care" law adopted in 1993, in part as a result of that State's HEALTHY PEOPLE 2000 process.

Another critical benefit of the HEALTHY PEOPLE 2000 process is that it provides States with a framework for evaluating public health programs and interventions. In Texas, it has become common practice for public health programs to integrate year 2000 objectives into their evaluation activities. *Healthy Texans* has provided programs such as the Texas Performance Based Objectives project, the Civil/Military project, and Shots Across Texas with a performance standard against which to measure program impact and outcomes.

Legislative Support and Development

Formulating and promoting statewide disease prevention and health promotion objectives has been a boon for States' support and development of legislative initiatives. States stressed that having a statewide blueprint for improving the population's health, one which represents statewide consensus from a broad cross-section of public and private sector interests alike, greatly facilitates lawmaking and appropriations. Health officials are able to use the objectives as a framework with legislators, not only to justify the need for various program initiatives, but to demonstrate the success of health interventions and the return on investment of public resources.

Although not specifically asked whether they had used objectives for legislative activity, about one-third of the States queried mentioned legislative work as one of their important implementation activities. The most frequently cited specific legislative success was the passage of clean indoor air legislation. Four States and territories—Delaware, Guam, Utah, and Vermont—attributed success in passing such legislation to their health objectives framework.

The Rhode Island Department of Health has been successful in using the objectives to win legislative approval for new requirements related to automobile and boat safety and radon control, as well as for new minority health programs funded by a tobacco tax. The Department anticipates proposing new legislation in the areas of tobacco control and driving restrictions for minors. Likewise, in addition to its clean indoor air laws, Vermont's legislative successes have also been numerous, including passages of bills related to lead abatement, immunizations, and seat belt usage.

Texas has developed a series of legislative profiles, one for each of the 31 State legislative districts, to educate legislators on the health status of their constituents and to encourage the use of data for local and State decision making.

Some States attempted to use their objectives as a basis for more broad-sweeping legislative initiatives, such as systems reform measures or department reorganization. Although it did not win approval from the State legislature, Kentucky introduced legislation in both 1992 and 1994 that would have revised the mission and

statutory authority of the Department of Health Services to be directly related to the State health objectives.

Community Planning Projects

Successful attainment of statewide objectives requires the commitment of agencies and organizations at the community level, where most public health services are provided. Recognizing this, many States used their statewide health objectives framework as a catalyst for implementation activities at the local level, supporting or participating in popular community planning and assessment processes such as APEX/PH (Assessment Protocol for Excellence in Public Health) or PATCH (Planned Approach To Community Health).

Several States provided examples of locally-oriented activities:

- The Alaska Department of Health and Social Services assisted 15 communities in local health planning efforts using the PATCH model.
- The Director of the Arkansas Department of Health identified community-based planning among her top priorities for the agency.
- The State Health Office of the Florida Department of Health and Rehabilitative Services is moving forward with a goal of developing comprehensive, community-based health promotion and wellness programs throughout the State. The State Health Office funds demonstration projects in three counties and provides training and technical assistance based on the PATCH model.
- The Illinois Project for Local Assessment of Needs (IPLAN) established a strategy for addressing communities' most serious health problems. As part of the certification requirements governing Illinois' health departments, 86 local health departments completed a local community health assessment and developed a corresponding community health plan to address priority needs in order to meet national HEALTHY PEOPLE 2000 objectives.
- A number of counties in Iowa have used *Healthy Iowans 2000* as a local planning catalyst. In addition, *Healthy Iowans 2000*, the Prevention Block Grant, and APEX/PH were used as the basis for a series of "Ounces of Prevention" meetings in each of the 19 counties in Iowa.
- The State and local public health agencies in Michigan have jointly initiated a community health assessment process to analyze health status, risks, and resources systematically and to develop and implement strategies for improving community health.
- In North Carolina, a State-level Office of Healthy North Carolinians was created to assist county- and community-level coalitions in setting their goals and objectives. In the 2 years since its creation, more than half of the counties in the State are in some stage of *Healthy Carolinians* activities, including 35 in the planning stages and 21 with active task forces.

- The *Healthy Texans* and Healthy People objectives have served as the foundation for numerous community-level strategic planning processes in Texas. In addition, a number of colleges and universities there have incorporated year 2000 objectives into their curriculum.
- Information about HEALTHY PEOPLE 2000 has been disseminated through the Wyoming Department of Health's PATCH communities.

Dissemination Efforts

The majority of responding States indicated that newsletters, periodicals, press releases, and other media tools were effective means for promoting their State objectives, related program activities, and progress toward meeting the objectives. Some States publish a periodic newsletter devoted exclusively to their HEALTHY PEOPLE 2000 activities while others dedicated portions of health department reports and publications for providing updates on their statewide activities. For example, in North Carolina, the Office of Healthy Carolinians—in conjunction with the State Center for Health and Environmental Statistics—produces a quarterly newsletter, *Target 2000*, and will produce a biennial trend analysis report to keep local coalitions informed of ongoing activities and to highlight objective areas.

In the majority of States, the objective-setting process resulted in the publication of a statewide plan, similar to the national *Healthy People 2000* document, which includes State priority areas, statewide goals, and specific objectives. In general, these plans are widely distributed to public agencies and private organizations throughout the State, and serve as a reference for Healthy People activities in the States. Several States indicated that they have or are planning to produce a midcourse review documenting progress made toward meeting their State objectives. The Michigan Department of Public Health has prepared an annual report describing the successful implementation of strategies under *Healthy Michigan 2000* and plans to issue a biennial surveillance report for monitoring the health status and risk reduction objectives contained in their plan. Several States, including Delaware and Maine, fielded numerous requests by private groups for senior staff presentations on their Healthy People initiatives. In Nebraska, health department staff frequently make presentations to university classes.

Another common strategy utilized by States to promote their Healthy People activities is conducting conferences, workshops, and other training programs. Healthy People initiatives in Iowa and Vermont will be featured in upcoming conferences on health prevention. During the conference, Iowa also will conduct a midcourse review. In Alaska, *Healthy Alaskans 2000* has been one of the major topics at each of the past three Alaska Health Summit conferences, Alaska's main conference on public health issues. Texas has taken a technological approach to promoting their *Healthy Texans* program. With funding from CDC, Texas has developed the *Healthy Texans* electronic bulletin board, operated by the Bureau of State Health Data and Policy Analysis. The target audiences include local health departments, regional health departments, and community-based and other organizations.

Statewide Partnerships

One result of the objective-setting process often cited by States was increased collaboration between the health department and other State agencies. Missouri indicated that the HEALTHY PEOPLE 2000 process has led to improved policy coordination and collaboration between the Department of Health and other executive agencies which are undergoing a statewide strategic planning initiative.

In South Carolina, collaboration and coalition building are important ingredients in the statewide effort to make progress toward the State objectives. The emphasis of *South Carolina Healthy People 2000* is on the 11 local Healthy People coalitions which focus on objectives and objective areas important to their communities. Each coalition has a local coordinator who works closely with State level staff to develop and implement Healthy People activities at the grass roots level.

Most States identified private sector involvement as an integral part of their implementation efforts. As part of health care reform, the Minnesota Department of Health established community health planning forums, called Regional Coordinating Boards, responsible for planning activities to meet public health goals, including those related to Minnesota's Year 2000 Objectives. Many States have established these types of planning groups, which typically include private organizations such as provider groups and health insurance groups, to assist in the development of activities for meeting State objectives. According to the Iowa Department of Health, the private/voluntary sector has, or shares major responsibility for, 20 percent of the 338 action steps in *Healthy Iowans 2000*.

In addition to working with State agencies, some private groups have independently undertaken health promotion and disease prevention activities related to State objectives. The Voluntary Hospitals Association of New Jersey adopted tobacco objectives and mounted a campaign called "Stay Healthy New Jersey" to prevent and control underage tobacco use and to promote a smoke-free environment.

Not only are private organizations sponsoring prevention and health promotion activities related to their State's Healthy People program, they are also incorporating the State objectives into their own planning and activities. For example, in Maine, the American Cancer Society used the State objectives to redesign their core activities. In Tennessee, the State objectives are used by the Health Facilities Commission in the Certificate of Need process and by the Perinatal Association. Several universities in Texas—including Baylor, Texas A&M, and the University of Texas—have integrated year 2000 information into the curriculum of their public health, medicine, public policy, and social work programs.

Additional Challenges and Problems

In addition to providing information on the successes of their objective-setting and implementation activities, States also identified some of the major challenges they face in their implementation activities. The most common response was lack of

funding for program activities related to State objectives. For many States, no additional State funds were appropriated specifically to address reaching the health promotion and disease prevention objectives for the year 2000. In States where a small percentage of the health department's budget comes from the State general fund, it is difficult for Healthy People programs to compete with other established and new programs for funding. As noted by one State contact, this problem is exacerbated because improvements in health outcomes related to the objectives often occur over the long term, are difficult to demonstrate and, therefore, are vulnerable to budget cuts. In States where the health department is being downsized, new initiatives receive minimal funding.

In addition to limited funding, many States cited coordination between the health department and other State agencies, such as the mental health, education, and environmental health departments, as a major obstacle. As Vermont officials suggested, the challenge exists in trying to pull together all statewide activities which support *Healthy Vermonters 2000*, beyond those activities within the Department of Health. According to officials in Rhode Island, successful sharing of responsibility across State agencies required commitment throughout each agency, from the program level to top management, to work through problems in communication and coordination and to resolve different orientations toward problem solving.

Echoing these concerns, Arizona health officials stated that, although the *Arizona 2000* planning process was a statewide effort involving a consortium of public, private, and voluntary representatives, the issues of ownership and shared responsibilities for implementation will require constant attention. For many State health departments, the challenge of coordination is internal—both intra- and interdepartmentally—and external, with nongovernmental organizations. In Washington State, their outcome standards (objectives) were developed and endorsed by a broad-based group of public and private representatives, whose continued cooperation and collaboration will be necessary to achieve these measures. As noted by Guam, without the continual assistance of the public sector, private organizations would not conduct activities related to Guam's objectives on their own.

TRACKING PROGRESS TOWARD ACHIEVING OBJECTIVES

Data Systems Development to Monitor Progress

Using their health objectives as a catalyst, a number of States have been able to improve their data systems and surveillance capabilities. Some of the more frequently cited improvements in information systems included establishing disease registries to facilitate implementation of selected objectives, enhancing the Behavioral Risk Factor Surveillance System, and developing statewide immunization information and tracking systems.

Several States' information system improvements were more global. For example, Alaska is planning to establish a uniform hospital discharge summary database and undertake a feasibility study on outpatient information outside the facility setting. This will allow improved disease and injury surveillance and improved ability for cost-effectiveness studies on prevention activities. Another State, which requested anonymity, is establishing a comprehensive health data system to collect and analyze data relating to costs, quality, and access to care.

Massachusetts has made surveillance a priority by improving the availability of health status data for community-based health promotion and disease prevention through the development of a user-friendly, on-line information service known as MassCHIP. This service will provide health department staff, health providers, and community agencies' easy access to 18 health status, health outcome, program utilization, and demographic data sets.

Gaps in Data to Evaluate Success

Not surprisingly, a large number of States indicated that they lacked the resources and infrastructure to collect the data necessary for tracking progress toward State objectives. In Michigan, the Department of Public Health is currently in the process of establishing State-specific targets for its statewide objectives, which were adopted in 1993, and health officials there feel that the lack of data in some areas and limited resources for data collection and analysis will impede the process. In addition to having these common problems of insufficient resources and infrastructure, Hawaii experienced a unique problem with their baseline data. The baseline data were collected by an "outside" statistician, which did not allow sufficient time for consultation with internal program staff. When it came time to work with the baseline data, staff were not familiar with some of the statistical calculations used and questioned the accuracy of the data. As a result, the data have not been readily used.

Missouri indicated that they have been able to track some objectives and collect data on the progress being made. However, in the process, they have identified "problem objectives" for which no data can be collected. As a result of the gaps in available data, some of these objectives were revised and some were eliminated.

Several States cited problems not only with collecting State data but also collecting data at the local level and for specific programs and populations. Delaware indicated they have had difficulty collecting and analyzing data necessary to plan and track progress at the community level. In Delaware and many other States, these data are critical because their Healthy People activities are centered in communities and localities. With the exception of relatively few broad-based mortality measures, Florida has experienced a related but opposite problem: it has become increasingly difficult to establish statewide measures in Florida due to the movement in the State toward decision making at the local level.

In Minnesota, identifying gaps in population-based assessment data was an important outcome of setting and evaluating their statewide objectives. As a result, Preventive Health Block Grant funds have been targeted in specific areas to strengthen the capacity to assess population health trends.

Conclusion

PHS' HEALTHY PEOPLE 2000 effort, which is geared toward improving health status and promoting healthy lifestyles through quantifiable objectives, has been immensely successful in focusing National public health efforts on high-priority health problems. The fact that most States—which are the critical entities in carrying out strategies to achieve the national objectives—have established their own objectives that, in general, mirror the national objectives is testimony to this success.

In general, establishing, promoting, and working to achieve statewide disease prevention and health promotion objectives for the year 2000 has been a valuable experience for States. Statewide health objectives have been the impetus for identifying and allocating scarce public health resources, setting and justifying budgets, conceiving health policies and strategic plans, developing and evaluating programs, crafting and supporting legislation, cultivating public/private partnerships and coalition-building, and stimulating community planning and involvement. At the same time, if States are to be successful in achieving their health goals and objectives, they will have to overcome a great many challenges and obstacles, such as lack of funding for program activities related to the objectives, lack of resources for information infrastructure and objectives tracking, and the difficulty in engaging entities outside of public health departments to commit to the effort.

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THE HEALTHY PEOPLE 2000 CONSORTIUM: A MIDCOURSE REVIEW

History of the HEALTHY PEOPLE 2000 Consortium

Integral to the success of the entire HEALTHY PEOPLE 2000 initiative is the HEALTHY PEOPLE 2000 Consortium. This diverse group of over 330 private and public sector partners, including all the States, was formed in 1988 by the Public Health Service (PHS) in cooperation with the Institute of Medicine of the National Academy of Sciences.

Because HEALTHY PEOPLE 2000 was conceived as a national—not just a Federal—initiative, the philosophy of investing organizations in the initiative's success was essential to its development. Thus, a wide range of partners was recruited for the development of HEALTHY PEOPLE 2000 with the hope that they would ultimately play a vital role in the implementation of strategies to ensure the initiative's success. The growth of the Consortium since its inception and the achievement of the targets to date prove this philosophy was wise.

The strength of the Consortium lies in its diversity. Indeed, Consortium members are working in all 22 of the priority areas. Initially made up of 157 national organizations plus State and territorial health departments, it has grown to encompass 330 organizations and all 50 States. Member organizations represent diverse populations, institutions, and issues. Consortium members have widely differing missions and means of pursuing disease prevention and health promotion strategies. It is their creativity and flexibility that make them valuable partners on the journey to improving the Nation's health.

Conversely, for Consortium members, HEALTHY PEOPLE 2000 has proven to be a valuable tool as well. According to a 1994 survey of Consortium members conducted for the Deputy Assistant Secretary for Health (Public Affairs), 82 percent consider the objectives useful to their organizations. Consortium members use HEALTHY PEOPLE 2000 to pursue their own agendas, shaping their structures and their efforts to the content of HEALTHY PEOPLE 2000. The initiative serves both as a road map for action and a source of ideas from which to develop programs, determine policy, pursue funding, and mobilize membership. In addition, it allows the development of coalitions among groups who, before HEALTHY PEOPLE 2000, might not have seen themselves as striving toward the same goals.

Public Health Service Activities with the Consortium

PHS lead agencies for the HEALTHY PEOPLE 2000 priority areas all draw upon Consortium members for involvement in their efforts. As overall coordinator, the PHS Office of Disease Prevention and Health Promotion (ODPHP), a program office within the Office of the Assistant Secretary for Health, serves the HEALTHY PEOPLE

2000 Consortium in a variety of ways. ODPHP oversaw development of the objectives, the PHS monitoring structure, and the Consortium. In addition, ODPHP directed the implementation of the HEALTHY PEOPLE 2000 initiative. This included making grants to nine organizations to craft prevention activities for special populations such as older people, people with disabilities, and blacks. In this capacity, ODPHP also convenes HEALTHY PEOPLE 2000 Steering Committee meetings, organizes progress reviews on each of the priority areas and crosscutting areas for the Assistant Secretary for Health, and hosts an annual meeting of the Consortium to discuss progress, barriers, and ways to overcome them.

ODPHP staff also respond to Consortium member inquiries about available resources, current news on PHS activities, contacts, publications, and expert speakers. Consortium members request and receive advice on quality-of-life indicators, data on specific objectives, details of PHS efforts and marketing strategies, materials for information on the objectives, examples of interdisciplinary collaboration, information on the status of health care reform, funding sources, and feedback on prevention program proposals.

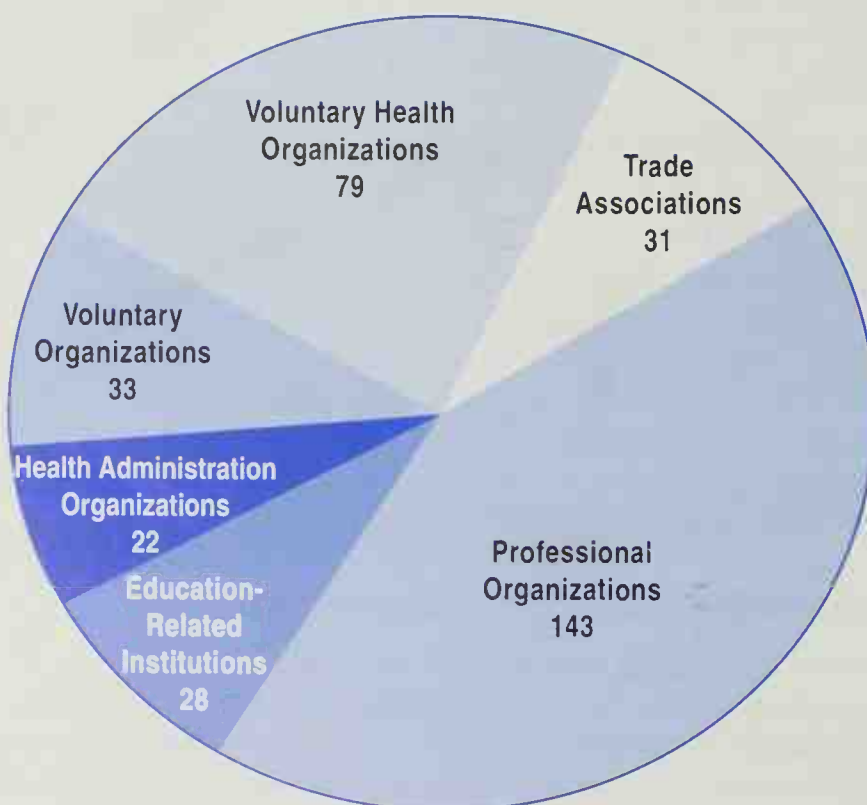
Consortium members stay abreast of each other's activities and those of the Federal Government through *UPDATE*, a bimonthly newsletter highlighting local activities related to HEALTHY PEOPLE 2000 and through publications such as the *Healthy People*

2000 Review. Publications such as resource lists for each priority area and *Progress Reports* support information sharing.

The Consortium Today

Figure 1 illustrates the diversity of the Consortium today; Figure 2 illustrates the target populations of the various Consortium members. These data were abstracted from the HEALTHY PEOPLE 2000 Consortium database from data provided by Consortium organizations themselves.

Figure 1.
Private and Voluntary Organizations
in the HEALTHY PEOPLE 2000 Consortium



Source: ODPHP, 2000 Trak database, 1995

The following section illustrates the variety of Consortium organization programs that directly support achievement of the Nation's prevention agenda. The examples showcase successes and inspire further good work; they serve as reminders of what is possible when commitment, creativity, and hard work are applied to a shared mission and vision.

Examples of Consortium Action

Many organizations from the private and voluntary sectors have taken the objectives and used them as a frame-

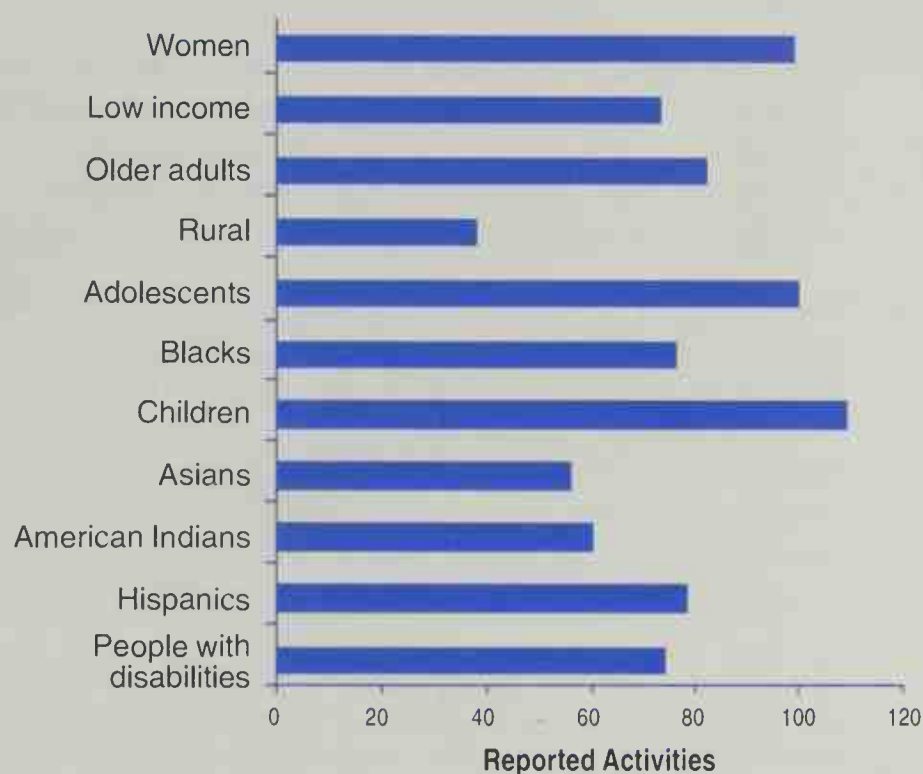
work for action on the prevention front. Although membership in the HEALTHY PEOPLE 2000 Consortium is purposely free and inclusive, the true "price" of participation is substantial: contributing to improving the Nation's health.

The three overarching goals of HEALTHY PEOPLE 2000 represent an underlying charge to change behavior—among institutions, policy makers, health care providers, community leaders, the media, public officials, and ultimately, individuals. Each of these entities has solid traditions, cultures, and bureaucracies; and each faces political pressure, fiscal constraints, and a range of other factors that make change of any kind difficult. Through the concerted actions of their memberships, Consortium organizations pool their expertise, resources, perspectives, and special interests to create positive momentum to help advance the health of the Nation.

A Focus on Publications

Wellness Councils of America (WELCOA) has demonstrated in multiple ways that its commitment to health goes beyond words. A key aspect of the WELCOA strategy has been to provide its membership with instructive publications. WELCOA developed *Health Promotion for All: Strategies for Reaching Diverse Populations at the Workplace* that links ethnic and racial health issues to worksite wellness and

Figure 2.
Reported Activities of the Consortium Targeting Special Populations



Source: ODPHP, 2000 Trak database, 1995

HEALTHY PEOPLE 2000. The booklet *Healthy People at the Worksite 2000* offers not only a guide for personnel in developing programs, but also 77 low-cost health promotion ideas. WELCOA provides incentives such as Well Workplace awards, which are based on HEALTHY PEOPLE 2000 priority areas.

The Association of State and Territorial Public Health Laboratory Directors created *LIFT 2000*, a report developed as a companion initiative to HEALTHY PEOPLE 2000. This report, which was sent to over 600 interested agencies and individuals, identifies the laboratory components of HEALTHY PEOPLE 2000, data and surveillance needs, and the role laboratory professionals can play in forwarding the prevention agenda.

The American Hospital Association developed *Healthy People 2000: America's Hospitals Respond*, a resource kit for hospital administrators to help mobilize health promotion initiatives throughout the country. The kit includes ideas for urban and rural communities and includes suggestions for hospitals "on a limited budget." Suggestions include using volunteers, hosting support groups, developing mother-daughter programs, forming partnerships with schools, reaching out to parents, teaching self-care in clinics, educating people about AIDS, teaching good nutritional practices, establishing a health information center, and offering free screening.

The National Recreation and Parks Association, recognizing its special role in promoting recreational programs and facilities for increased physical activity and community health promotion, has reached out to members, largely through dissemination of publications. For example, *Beyond Fun and Games, Emerging Roles of Public Recreation* highlights programs that illustrate the multidimensional potential for improved health through recreation.

The American School Health Association produced *Healthy Students 2000: An Agenda for Continuous Improvement in America's Schools* in 1994. This workbook is for educators developing or improving health programs in their schools. The information is based on results of demonstration projects funded by the U.S. Department of Education. The preface explains the usefulness of HEALTHY PEOPLE 2000 this way: "Using the national HEALTHY PEOPLE 2000 initiative provided the necessary link to behaviors of students that legitimized the project for the practitioners as well as providing a framework, which elevated the initiative from a small isolated program from the Cleveland district to an initiative responding to a national challenge." *Healthy Students 2000* presents case findings in a format that has wide applicability to professionals eager to make a difference in their own schools.

The American Dietetic Association (ADA) developed *Call to Action* to inspire its more than 64,000 members to pursue the nutrition objectives. This workbook outlines an implementation plan for the objectives and describes the ADA philosophy: "This workbook is the platform for involving all members of the ADA in one of the most comprehensive nutrition tracking efforts of the century. The ultimate value of the objectives will be the extent to which they help shape what we do toward improving the health of the Nation."

The National Dairy Council's *2000 and Counting* is a teaching guide with instructions, handouts, activity ideas, and background information on the nutrition objectives. Nutrition hints for "Healthy People on a Budget" and "Healthy Busy People," as well as colorful comparison cards and other learning enhancement tools are also part of the package.

A Focus on Special Events and Campaigns

The National Association of Children's Hospitals and Related Institutions' (NACHRI) HEALTHY CHILDREN 2000 Campaign focuses on the HEALTHY PEOPLE 2000 objectives targeting children using a multiyear effort to implement prevention programs in children's hospitals and their communities. NACHRI's Council on Child Health selected 10 specific health promotion themes, one for each year of the 10-year campaign. For example, the theme for 1991 was immunizations. Campaign materials include fact sheets showing prevalence data on the health problem and related HEALTHY PEOPLE 2000 objectives, hospital case studies, programming ideas, and resource information supporting the campaign.

The National SAFE KIDS Campaign's goal of decreasing unintentional injuries among children has resulted in a fundamental change in the way many adults think about childhood injuries, from a view that childhood injuries are "accidents" to a view that injuries are preventable. The campaign, which began as a means to reduce the number of preventable deaths among children seen at the National Children's Medical Center, has grown to a grassroots effort with coalitions in almost every State. Each coalition has its own style but is supported by the national office, which provides materials and policy recommendations for a school-based program, a family safety program, celebrity and media outreach, and lobbying State legislatures. The campaign specifically promotes bicycle and automobile safety, increased helmet use, scald and burn prevention, drowning prevention, and other preventable fatalities.

The Produce for Better Health Foundation's 5 A Day For Better Health Program is one of the largest public/private partnerships in the country. Over 30,000 supermarkets and most of the State and Territorial health departments have become partners in this campaign to encourage Americans to consume more fruits and vegetables.

The Sugar Association has launched several educational programs focusing on good nutrition and exercise. For instance, in 1994 the Sugar Association worked in cooperation with the Food and Drug Administration and the U.S. Department of Agriculture on a program called LABEL POWER to educate consumers about the new nutrition labels. The association also cosponsors (with the National Recreation and Parks Association) Fuel for Fitness, a program that encourages behavioral change by linking fitness activities and dietary choices.

The American Academy of Otolaryngology-Head and Neck Surgery's "Through With Chew" and "Poisoning our Children: The Perils of Secondhand Smoke" campaigns spread the message about the dangers of both smoking and chewing

tobacco. The campaigns offer educational activities, brochures, videos, and advocacy materials.

The American Optometric Association's (AOA) "Healthy Vision 2000" is aimed at getting its membership to practice and preach prevention in the area of eye injury and preventable blindness. AOA has devoted journal articles, meetings, and resources to this effort.

The American Heart Association (AHA) and the National Stroke Association (NSA) have been instrumental in getting Americans to adopt healthier habits. Such campaigns as AHA's "Have a Heart" and NSA's "Be Stroke Smart" have played a part in reducing incidents of coronary disease and stroke.

The American Cancer Society (ACS) has been a major catalytic force behind cancer prevention for particular populations, with such successful programs as a school health cancer risk-reduction program for fourth through sixth graders called "Do it Yourself: Making Healthy Choices," "Taking Control," and "Eating Smart" nutrition campaigns, and tobacco activities involving the National Cancer Institute's ASSIST program. ACS is also involved with the Centers for Disease Control and Prevention's Breast and Cervical Cancer Program and minority-focused breast cancer education programs such as the "Circle of Life" for American Indian women.

The American Fund for Dental Health convened Oral Health 2000 to focus on the 16 oral health objectives through collaboration on prevention-based education, research, and service programs. The national consortium includes a range of partners from the private, voluntary, and government sectors and was launched through the National Institute of Dental Research. The consortium, continuing with corporate financial support, has embarked on such programs as smoking cessation and fluoride awareness and has reached out to labor unions, consumer groups, insurance companies, and other interested parties.

A Focus on Communities

The National Mental Health Association (NMHA) is doing its part to ensure that local mental health agencies have the know-how to implement prevention programs based on models that have already proved successful in reducing depression, suicide, and stress. NMHA provides local agencies with technical assistance, educational materials, and information on scientifically validated prevention approaches. The Community Prevention Services Program has targeted 10 communities around the country for specific training.

The American Public Health Association's (APHA) Model Standards Project—developed with sponsorship by CDC in collaboration with the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, and the Association of Schools of Public Health—promotes use of model standards in communities working to achieve the HEALTHY PEOPLE 2000 objectives.

APHA has done extensive outreach, developed a Peer Assistance Network, and produced and disseminated materials to communities about community processes and standards available to them. Key among APHA's publications are *Healthy Communities 2000: Model Standards* and *The Guide to Implementing Model Standards: Eleven Steps Toward a Healthy Community*.

The National Civic League (NCL) has been a catalyst behind the ever-growing Healthy Communities movement. This 100-year-old Colorado-based nonprofit organization has devoted its time and resources to spreading the word and sharing its wisdom with communities about how to develop collaborative, broad-based prevention programs at the local level. HEALTHY PEOPLE 2000 objectives are used frequently in community plans and as a framework for goal-setting on a local level. NCL's programs include the National Healthy Communities Initiative and the Healthy Communities Action Project. Beyond extensive technical assistance, where NCL offers expertise in facilitation, design, and strategic planning, NCL has published *Healthy Communities Handbook*, *Healthy Communities Directory*, *Healthy Communities Resource Guide*, and *Healthy Communities Storybook*.

The National Black Nurses Association (NBNA), with funding from the Division of Nursing of the Health Resources and Services Administration, is working to encourage prevention activities among its branches and chapters. The association developed a Community Collaboration Model with attention to such health topics as AIDS prevention and control. Forty percent of the NBNA chapters sponsor education programs in schools, the worksite, and other sites in the community. The prevention programs cater to the special needs of blacks and most recently have focused on adolescents. In the area of cardiovascular disease, 88 percent of NBNA chapters have provided screening and referral for hypertension, cholesterol, diet and exercise, and smoking cessation. The group has worked closely with such key community institutions as churches and voluntary groups and has embarked on efforts to diversify the workforce in the health care field.

The American College of Sports Medicine (ACSM) has built a grassroots community-based organization that takes the objectives straight to the public and professionals through volunteers. ACSM equips volunteers with information and materials to spread the prevention message in their communities. The college has an Ad Hoc Committee on HEALTHY PEOPLE 2000, with 12 regional and 47 State representatives. Committee members share information about progress and highlight regional efforts in the quarterly newsletter, *The Goal Post*. Promotional material is supplemented with educational information and such tools as slide sets.

A Focus on Special Populations and Settings

The National Medical Association (NMA) represents 16,000 black and other physicians across the country. NMA has set its own year 2000 objectives: "(1) Demonstrate the effectiveness of coalition teams directed by physicians who engage in disease prevention and health promotion in local communities. (2) Develop a

practical and replicable applications model. (3) Integrate this project with existing local programs that are funded by the private sector and public agencies.” The NMA’s Community Coalition Project has been implemented in 14 cities and involves community presentations, mass media messages, and various other means to reach three targeted age groups of blacks: 15–24 years, 25–44 years, and 53–64 years. Coalition teams have been formed in each site, with a physician team leader and a range of other participants, including allied health professionals, clergy, and community leaders.

The focus of the National Coalition of Hispanic Health and Human Service Organizations (COSSMHO) “Es Mejor Prevenir que Curar/An Ounce of Prevention” project is to improve the health status of Hispanic Americans. COSSMHO provides leadership and technical assistance to community-based organizations to foster the development of health promotion and disease prevention programs that effectively target Hispanics. COSSMHO conducts research and trains health care professionals in the cross-cultural delivery of health services and has developed *Health Objectives: A Hispanic Prevention Agenda*, which outlines specific implementation strategies for using HEALTHY PEOPLE 2000 with Hispanic populations. COSSMHO also works closely with the National Hispanic Leadership Initiative on Cancer sponsored by the National Cancer Institute.

“Healthier Youth by the Year 2000” was developed through funding by PHS to the American Medical Association (AMA) via their National Coalition on Adolescent Health. AMA formed a year 2000 task force to come up with strategies to improve adolescent health. The task force, made up of 20 national membership organizations (almost all HEALTHY PEOPLE 2000 Consortium members themselves), capitalizes on the strong networks that are already part of AMA. A newsletter, *Target 2000*, includes news on model State and local programs for adolescents, interviews with adolescent health experts, listings of relevant new publications and funding sources, and planning tips. The National Coalition on Adolescent Health developed the National Adolescent Health Promotion Network, an electronic network with 7,000 users, including mental health workers, social services administrators, advocates, and health educators. Members are offered free use of the network to enhance their work with adolescents.

The American Association of Retired Persons (AARP) has been the lead organization on HEALTHY PEOPLE 2000 activities related to older adults. AARP, with help from a PHS cooperative agreement, has crafted health promotion programs targeting older Americans. AARP developed and disseminated several publications and provided leadership for numerous prevention programs that draw upon the HEALTHY PEOPLE 2000 objectives, particularly those relating to osteoporosis, nutrition, and falls. AARP also gave awards to organizations conducting model programs around the country.

The American Association of School Administrators, which represents about 19,000 superintendents, principals, and school district leaders, carried out its commitment to the Consortium by promoting "Healthy Kids for the Year 2000." This project builds interest in the HEALTHY PEOPLE 2000 objectives targeting school-age children through intensive promotion of the merits of comprehensive school health education programs.

The subtitle of the American College Health Association's (ACHA) Healthy Campus 2000 initiative says it all: "Making It Happen." This organization's interest grew out of concern that insufficient attention was being paid to 18- to 25-year-olds. ACHA was part of the Task Force on National Health Objectives in Higher Education that recognized the tremendous opportunities for promotion and preventive services at college health centers. ACHA's Healthy Campus 2000 project helps link the national health objectives to individual campus communities.

Conclusion

The organizations highlighted in this chapter were selected because they are examples of Consortium member action to support HEALTHY PEOPLE 2000. In no way do the examples represent a complete list of all the activities currently underway nationwide. Rather, the examples describe a rich diversity of approaches to addressing many different health concerns, special populations, and settings. All of these examples reaffirm the belief that the HEALTHY PEOPLE 2000 targets are achievable, even surpassable, given the right combination of collaborators.

In stepping back to assess progress, unquestionably the Consortium's involvement in advancing the objectives has been integral to HEALTHY PEOPLE 2000's success to date. Looking forward, it is clear the Consortium will continue to be vital to the achievement of the objectives by the end of the decade.

APPENDIX A

1995 Summary List of Objectives

With 1995 Revisions

* Duplicate objectives which appear in two or more priority areas are marked with an asterisk alongside the objective number.

Physical Activity and Fitness

Health Status Objectives

1.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

Special Population Target

	Coronary Deaths (per 100,000)	1987 Baseline	2000 Target
1.1a	Blacks	168	115

1.2* Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 in 1976–80)

Special Population Targets

	Overweight Prevalence	1976–80 Baseline [†]	2000 Target
1.2a	Low-income women aged 20 and older	37%	25%
1.2b	Black women aged 20 and older	44%	30%
1.2c	Hispanic women aged 20 and older		25%
	Mexican-American women	39% [‡]	
	Cuban women	34% [‡]	
	Puerto Rican women	37% [‡]	
1.2d	American Indians/Alaska Natives	29–75% [§]	30%
1.2e	People with disabilities	36% ^{††}	25%
1.2f	Women with high blood pressure	50%	41%
1.2g	Men with high blood pressure	39%	35%
1.2h	Mexican-American men	30% [‡]	25%

[†]Baseline for people aged 20–74 [‡]1982–84 baseline for Hispanics aged 20–74 [§]1984–88 estimates for different tribes ^{††}1985 baseline for people aged 20–74 who report any limitation in activity due to chronic conditions derived from self-reported height and weight

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

Risk Reduction Objectives

1.3* Increase to at least 30 percent the proportion of people aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes 5 or more times per week and 16 percent were active 7 or more times per week in 1985)

Special Population Target

	Moderate Physical Activity	1991 Baseline	2000 Target
1.3a	Hispanics aged 18 and older 5 or more times per week	20%	25%

Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.

1.4 Increase to at least 20 percent the proportion of people aged 18 and older and to at least 75 percent the proportion of children and adolescents aged 6–17 who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion. (Baseline: 12 percent for people aged 18 and older in 1985; 66 percent for youth aged 10–17 in 1984)

Special Population Targets

	Vigorous Physical Activity	1985 Baseline	2000 Target
1.4a	Lower-income people aged 18 and older (annual family income <\$20,000)	7%	12%
		1991 Baseline	2000 Target
1.4b	Blacks aged 18 and older	11.5%	17%
1.4c	Hispanics aged 18 years	11.9%	17%

Note: Vigorous physical activities are rhythmic, repetitive physical activities that use large muscle groups at 60 percent or more of maximum heart rate for age. An exercise heart rate of 60 percent of maximum heart rate for age is about 50 percent of maximal cardiorespiratory capacity and is sufficient for cardiorespiratory conditioning. Maximum heart rate equals roughly 220 beats per minute minus age.

1.5 Reduce to no more than 15 percent the proportion of people aged 6 and older who engage in no leisure-time physical activity. (Baseline: 24 percent for people aged 18 and older in 1985)

Special Population Targets

	<i>No Leisure-Time Physical Activity</i>	<i>1985 Baseline</i>	<i>2000 Target</i>
1.5a	People aged 65 and older	43%	22%
1.5b	People with disabilities	35% [†]	20%
1.5c	Lower-income people (annual family income <20,000)	32% [†]	17%
		<i>1991 Baseline</i>	<i>2000 Target</i>
1.5d	Blacks aged 18 and older	28%	20%
1.5e	Hispanics aged 18 and older	34%	25%
1.5f	American Indians/Alaska Natives	29%	21%

[†]Baseline for people aged 18 and older

Note: For this objective, people with disabilities are people who report any limitation in activity due to chronic conditions.

1.6 Increase to at least 40 percent the proportion of people aged 6 and older who regularly perform physical activities that enhance and maintain muscular strength, muscular endurance, and flexibility. (Baseline data unavailable)

1.7* Increase to at least 50 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practices combined with regular physical activity to attain an appropriate body weight. (Baseline: 30 percent of overweight women and 25 percent of overweight men for people aged 18 and older in 1985)

Special Population Targets

	<i>Adoption of Weight-Loss Practices</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
1.7a	Overweight Hispanic males aged 18 and older	15%	24%
1.7b	Overweight Hispanic females aged 18 and older	13%	22%

Services and Protection Objectives

1.8 Increase to at least 50 percent the proportion of children and adolescents in 1st–12th grade who participate in daily school physical education. (Baseline: 36 percent in 1984–86)

1.9 Increase to at least 50 percent the proportion of school physical education class time that students spend being physically active, preferably engaged in lifetime physical activities. (Baseline: Students spent an estimated 27 percent of class time being physically active in 1983)

Note: Lifetime activities are activities that may be readily carried into adulthood because they generally need only one or two people. Examples include swimming, bicycling, jogging, and racquet sports. Also counted as lifetime activities are vigorous social activities such as dancing. Competitive group sports and activities typically played only by young children such as group games are excluded.

Appendix A: 1995 Summary List of Objectives

1.10 Increase the proportion of worksites offering employer-sponsored physical activity and fitness programs as follows:

<i>Worksite Size</i>	<i>1985 Baseline</i>	<i>2000 Target</i>
50–99 employees	14%	20%
100–249 employees	23%	35%
250–749 employees	32%	50%
≥750 employees	54%	80%

1.11 Increase community availability and accessibility of physical activity and fitness facilities as follows:

<i>Facility</i>	<i>1986 Baseline</i>	<i>2000 Target</i>
Hiking, biking, and fitness trail miles	1 per 71,000 people	1 per 10,000 people
Public swimming pools	1 per 53,000 people	1 per 25,000 people
Acres of park and recreation open space	1.8 per 1,000 people (553 people per managed acre)	4 per 1,000 people (250 people per managed acre)

1.12 Increase to at least 50 percent the proportion of primary care providers who routinely assess and counsel their patients regarding the frequency, duration, type, and intensity of each patient's physical activity practices. (Baseline: Physicians provided exercise counseling for about 30 percent of sedentary patients in 1988)

1995 Addition

Health Status Objective

1.13* Reduce to no more than 90 per 1,000 people the proportion of all people aged 65 and older who have difficulty in performing two or more personal care activities thereby preserving independence. (Baseline: 111 per 1,000 in 1984–85)

Special Population Targets

	<i>Difficulty Performing Self Care (per 1,000)</i>	<i>1984–85 Baseline</i>	<i>2000 Target</i>
1.13a	People aged 85 and older	371	325
1.13b	Blacks aged 65 and older	112	98

Note: Personal care activities are bathing, dressing, using the toilet, getting in and out of bed or chair, and eating.

Nutrition

Health Status Objectives

2.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

Special Population Target

	Coronary Deaths (per 100,000)	1987 Baseline	2000 Target
2.1a Blacks		168	115

2.2* Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people. (Age-adjusted baseline: 134 per 100,000 in 1987)

Note: In its publications, the National Cancer Institute age-adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this health status objective differ from those presented here.

Special Population Target

	Cancer Deaths (per 100,000)	1990 Baseline	2000 Target
2.2a Blacks		182	175

2.3* Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 in 1976–80)

Special Population Targets

	Overweight Prevalence	1976–80 Baseline [†]	2000 Target
2.3a Low-income women aged 20 and older		37%	25%
2.3b Black women aged 20 and older		44%	30%
2.3c Hispanic women aged 20 and older			25%
	Mexican-American women	39% [‡]	
	Cuban women	34% [‡]	
	Puerto Rican women	37% [‡]	
2.3d American Indians/Alaska Natives		29–75% [§]	30%
2.3e People with disabilities		36% ^{††}	25%
2.3f Women with high blood pressure		50%	41%
2.3g Men with high blood pressure		39%	35%
2.3h Mexican-American men		30% [‡]	25%

[†]Baseline for people aged 20–74 [‡]1982–84 baseline for Hispanics aged 20–74 [§]1984–88 estimates for different tribes ^{††}1985 baseline for people aged 20–74 who report any limitation in activity due to chronic conditions derived from self-reported height and weight

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and

Appendix A: 1995 Summary List of Objectives

Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

2.4 Reduce growth retardation among low-income children aged 5 and younger to less than 10 percent. (Baseline: 11 percent among low-income children aged 5 and younger in 1988.)

Special Population Targets

	<i>Prevalence of Short Stature</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
2.4a	Low-income black children <age 1	15%	10%
2.4b	Low-income Hispanic children <age 1	13%	10%
2.4c	Low-income Hispanic children aged 1	16%	10%
2.4d	Low-income Asian/Pacific Islander children aged 1	14%	10%
2.4e	Low-income Asian/Pacific Islander children aged 2–4	16%	10%

Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population derived from the 1971–74 NHANES.

Risk Reduction Objectives

2.5* Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged 2 and older. (Baseline: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [CSFII]). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines'* average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 21 percent met the goal for fat and 21 percent met the goal for saturated fat based on 2-day dietary data from the 1988–91 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

2.6* Increase complex carbohydrate and fiber-containing foods in the diets of people aged 2 and older to an average of 5 or more daily servings for vegetables (including legumes) and fruits, and to an average of 6 or more daily servings for grain products. (Baseline: 4.1 servings of vegetables and fruits and 5.8 servings of grain products for people aged 2 and older based on 3-day dietary data from the 1989–91 CSFII). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines'* average daily goal of 5 or more

servings of vegetables/fruits, and increase to at least 50 percent the proportion who meet the goal of 6 or more servings of grain products. (Baseline: 29 percent met the goal for fruits and vegetables, and 40 percent met the goal for grain products for people aged 2 and older based on 3-day dietary data in the 1989–91 CSFII)

Note: The definition of vegetables, fruits, and grain products and serving size designations are derived from The Food Guide Pyramid. Vegetable, fruit, and grain ingredients from mixtures are included in the total, and fractions of servings are counted.

2.7* Increase to at least 50 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practices combined with regular physical activity to attain an appropriate body weight. (Baseline: 30 percent of overweight women and 25 percent of overweight men for people aged 18 and older in 1985)

Special Population Targets

	<i>Adoption of Weight-Loss Practices</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
2.7a	Overweight Hispanic males aged 18 and older	15%	24%
2.7b	Overweight Hispanic females aged 18 and older	13%	22%

2.8 Increase calcium intake so at least 50 percent of people aged 11–24 and 50 percent of pregnant and lactating women consume an average of 3 or more daily servings of foods rich in calcium, and at least 75 percent of children aged 2–10 and 50 percent of people aged 25 and older consume an average of 2 or more servings daily. (Baseline: 20 percent of people 11–24; 22 percent of pregnant and lactating women consumed an average of 3 or more servings; 48 percent of children aged 2–10 and 21 percent of people aged 25 and older who were not pregnant or lactating consumed an average of 2 or more servings based on 3-day dietary data from the 1989–91 CSFII)

Special Population Target

	<i>Percent Meeting Goal</i>	<i>1989–91 Baseline</i>	<i>2000 Target</i>
2.8a	Females aged 11–24	13%	50%

Note: Calcium-rich foods are defined for this purpose as milk and milk products, and the recommended number of servings and the age groupings are based on The Food Guide Pyramid and on the National Research Council's Recommended Dietary Allowance (RDA) for calcium, respectively. Milk and milk product ingredients in mixtures are included, and fractions of servings are counted.

2.9 Decrease salt and sodium intake so at least 65 percent of home meal preparers prepare foods without adding salt, at least 80 percent of people avoid using salt at the table, and at least 40 percent of adults regularly purchase foods modified or lower in sodium. (Baseline: 43 percent of main meal preparers did not use salt in food preparation based on the 1989–90 CSFII, and 60 percent of individuals never or rarely used salt at the table based on the 1989–91 CSFII; 20 percent of all people aged 18 and older regularly purchased foods with reduced salt and sodium content in 1988)

Appendix A: 1995 Summary List of Objectives

2.10 Reduce iron deficiency to less than 3 percent among children aged 1–4 and among women of childbearing age. (Baseline: 9 percent for children aged 1–2, 4 percent for children aged 3–4, and 5 percent for women aged 20–44 in 1976–80)

Special Population Targets

	<i>Iron Deficiency Prevalence</i>	<i>1976–80 Baseline</i>	<i>2000 Target</i>
2.10a	Low-income children aged 1–2	21%	10%
2.10b	Low-income children aged 3–4	10%	5%
2.10c	Low-income women of childbearing age	8% [†]	4%
	<i>Anemia Prevalence</i>	<i>1983–85 Baseline</i>	<i>2000 Target</i>
2.10d	Alaska Native children aged 1–5	22–28%	10%
2.10e	Black, low-income pregnant women (third trimester)	41% [‡]	20%

[†]Baseline for women aged 20–44 [‡]1988 baseline for women aged 15–44

Note: Iron deficiency is defined as having abnormal results for 2 or more of the following tests: mean corpuscular volume, erythrocyte protoporphyrin, and transferrin saturation. Anemia is used as an index of iron deficiency. Anemia among Alaska Native children was defined as hemoglobin <11 gm/dL or hematocrit <34 percent. For pregnant women in the third trimester, anemia was defined according to CDC criteria. The above prevalences of iron deficiency and anemia may be due to inadequate dietary iron intakes or to inflammatory conditions and infections. For anemia, genetics may also be a factor.

2.11* Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until their babies are 5–6 months old. (Baseline: 54 percent during early postpartum and 21 percent who are still breastfeeding at 5–6 months in 1988)

Special Population Targets

	<i>Mothers Breastfeeding Their Babies During Early Postpartum Period:</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
2.11a	Low-income mothers	32%	75%
2.11b	Black mothers	25%	75%
2.11c	Hispanic mothers	51%	75%
2.11d	American Indian/ Alaska Native mothers	47%	75%
	<i>At Age 5–6 Months:</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
2.11a	Low-income mothers	9%	50%
2.11b	Black mothers	8%	50%
2.11c	Hispanic mothers	16%	50%
2.11d	American Indian/ Alaska Native mothers	28%	50%

Note: The definition used for breastfeeding includes exclusive use of human milk or the use of human milk with a supplemental bottle of formula or cow's milk.

2.12* Increase to at least 75 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay. (Baseline: 55 percent for parents and caregivers of children 6–23 months in 1991)

Special Population Targets

	<i>Appropriate Feeding Practices</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
2.12a	Parents and caregivers with less than high school education	36%	65%
2.12b	American Indian/Alaska Native parents and caregivers	74% [§]	65%
2.12c	Blacks	48%	65%
2.12d	Hispanics	39%	65%

[§]1985–89 data in four IHS Service Areas in a pilot project

* Note: Percentage of parents and caregivers of children 6–23 months. Appropriate feeding practices are that the child no longer uses a bottle, or if the child still uses a bottle that no bottle was given at bedtime, excluding bottles with plain water, during the past 2 weeks.

2.13 Increase to at least 85 percent the proportion of people aged 18 and older who use food labels to make nutritious food selections. (Baseline: 74 percent of people aged 18 and older used labels to make food selections in 1988)

Services and Protection Objectives

2.14 Achieve useful and informative nutrition labeling for virtually all processed foods and at least 40 percent of ready-to-eat carry-away foods. Achieve compliance by at least 90 percent of retailers with the voluntary labeling of fresh meats, poultry, seafood, fruits, and vegetables. (Baseline: 60 percent of sales of processed foods regulated by FDA had nutrition labeling in 1988; 77 percent and 75 percent compliance by retailers for fresh produce and fresh seafood respectively based on the 1993 FDA Survey on Labeling of Raw Produce and Raw Fish; baseline data on carry-away foods and fresh meat and poultry are unavailable)

2.15 Increase to at least 5,000 brand items the availability of processed food products that are reduced in fat and saturated fat. (Baseline: 2,500 items reduced in fat in 1986)

Note: A brand item is defined as a particular flavor and/or size of a specific brand and is typically the consumer unit of purchase.

2.16 Increase to at least 90 percent the proportion of restaurants and institutional food service operations that offer identifiable low-fat, low-calorie food choices, consistent with the *Dietary Guidelines for Americans*. (Baseline: 70 percent of fast food and family restaurant chains with 350 or more units had at least one low-fat, low-calorie item on their menu in 1989)

2.17 Increase to at least 90 percent the proportion of school lunch and breakfast services and child care food services with menus that are consistent with the nutri-

tion principles in the *Dietary Guidelines for Americans*. (Baseline: 1 percent of schools offered lunches that provided an average of 30 percent or less of calories from total fat, and less than 1 percent offered lunches that provided an average of less than 10 percent of calories from saturated fat based on the 1992 School Nutrition Dietary Assessment Study. Of the schools participating in the USDA school breakfast program, 44 percent offered breakfasts that provided an average of 30 percent or less of calories from total fat, and 4 percent offered breakfasts that provided an average of less than 10 percent of calories from saturated fat in 1992)

2.18 Increase to at least 80 percent the receipt of home food services by people aged 65 and older who have difficulty in preparing their own meals or are otherwise in need of home-delivered meals. (Baseline: 7 percent in 1991)

2.19 Increase to at least 75 percent the proportion of the Nation's schools that provide nutrition education from preschool–12th grade, preferably as part of comprehensive school health education. (Baseline: 60 percent in 1991)

2.20 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer nutrition education and/or weight management programs for employees. (Baseline: 17 percent offered nutrition education activities and 15 percent offered weight control activities in 1985)

2.21 Increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling and/or referral to qualified nutritionists or dietitians. (Baseline: Physicians provided diet counseling for an estimated 40 to 50 percent of patients in 1988)

1995 Additions

Health Status Objectives

2.22* Reduce stroke deaths to no more than 20 per 100,000 people. (Age-adjusted baseline: 30.3 per 100,000 in 1987)

Special Population Target

	<i>Stroke Deaths (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
2.22a Blacks		52.5	27

2.23* Reduce colorectal cancer deaths to no more than 13.2 per 100,000 people. (Age-adjusted baseline 14.4 per 100,000 in 1987)

2.24* Reduce diabetes to an incidence of no more than 2.5 per 1,000 people and a prevalence of 25 per 1,000 people (Baselines: 2.9 per 1,000 in 1986–88; 28 per 1,000 in 1986–88)

Special Population Targets

	<i>Prevalence of Diabetes (per 1,000) 1982–84 Baseline[†]</i>	<i>2000 Target</i>
2.24a American Indians/Alaska Natives	69 [‡]	62
2.24b Puerto Ricans	55	49
2.24c Mexican Americans	54	49
2.24d Cuban Americans	36	32
2.24e Blacks	36 [§]	32

[†]1982–84 baseline for people aged 20–74 [‡]1987 baseline for American Indians/Alaska Natives aged 15 and older [§]1987 baseline for blacks of all ages

Risk Reduction Objectives

2.25* Reduce the prevalence of blood cholesterol levels of 240 mg/dL or greater to no more than 20 percent among adults. (Baseline: 27 percent for people aged 20–74 in 1976–80, 29 percent for women and 25 percent for men)

2.26* Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control. (Baseline: 11 percent controlled among people aged 18–74 in 1976–80; an estimated 24 percent for people aged 18 and older in 1982–84)

Special Population Targets

	<i>High Blood Pressure Control</i>	<i>1976–80 Baseline</i>	<i>2000 Target</i>
2.26a Men with high blood pressure		6%	40%
		<i>1988–91 Baseline</i>	<i>2000 Target</i>
2.26b Mexican Americans with high blood pressure		14%	50%
2.26c Women aged 70 and older		19%	50%

Note: People with high blood pressure have blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or take antihypertensive medication. Blood pressure control is defined as maintaining a blood pressure less than 140 mm Hg systolic and 90 mm Hg diastolic. In the 1976–80 NHANES II, control of hypertension did not include nonpharmacologic treatment. In the 1988–91 NHANES III, those controlling their high blood pressure without medication (e.g. through weight loss, low-sodium diets, or restriction of alcohol) will be included.

2.27* Reduce the mean serum cholesterol level among adults to no more than 200 mg/dL. (Baseline: 213 mg/dL among people aged 20–74 in 1976–80, 211 mg/dL for men and 215 mg/dL for women)

Tobacco

Health Status Objectives

3.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

Special Population Target

	Coronary Deaths (per 100,000)	1987 Baseline	2000 Target
3.1a	Blacks	168	115

3.2* Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people. (Age-adjusted baseline: 38.5 per 100,000 in 1987)

Special Population Targets

	Lung Cancer Deaths (per 100,000)	1990 Baseline	2000 Target
3.2a	Females	25.6	27
3.2b	Black males	86.1	91

Note: In its publications, the National Cancer Institute age-adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this health status objective differ from those presented here.

3.3 Slow the rise in deaths for the total population from chronic obstructive pulmonary disease to achieve a rate of no more than 25 per 100,000 people. (Age-adjusted baseline: 18.9 per 100,000 in 1987)

Note: Deaths from chronic obstructive pulmonary disease include deaths due to chronic bronchitis, emphysema, asthma, and other chronic obstructive pulmonary diseases and allied conditions.

3.4* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older. (Baseline: 29 percent in 1987, 31 percent for men and 27 percent for women)

Special Population Targets

	Cigarette Smoking Prevalence	1987 Baseline	2000 Target
3.4a	People with a high school education or less aged 20 and older	34%	20%
3.4b	Blue-collar workers aged 18 and older	41%	20%
3.4c	Military personnel	42% [†]	20%
3.4d	Blacks aged 18 and older	33%	18%
3.4e	Hispanics aged 18 and older	24%	15%
3.4f	American Indians/Alaska Natives	42–70% [‡]	20%
3.4g	Southeast Asian men	55% [§]	20%
3.4h	Women of reproductive age	29% ^{††}	12%
3.4i	Pregnant women	25% ^{††}	10%
3.4j	Women who use oral contraceptives	36% ^{§§}	10%

[†]1988 baseline [‡]1979–87 estimates for different tribes [§]1984–88 baseline ^{††}Baseline for women aged 18–44 ^{‡‡}1985 baseline ^{§§}1983 baseline

Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes. Since 1992, estimates include some-day (intermittent) smokers.

Risk Reduction Objectives

3.5 Reduce the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20. (Baseline: 30 percent of youth had become regular cigarette smokers by ages 20–24 in 1987)

Special Population Target

	Initiation of Smoking	1987 Baseline	2000 Target
3.5a	Lower socioeconomic status youth [†]	40%	18%

[†]As measured by people aged 20–24 with a high school education or less

3.6 Increase to at least 50 percent the proportion of cigarette smokers aged 18 and older who stopped smoking cigarettes for at least 1 day during the preceding year. (Baseline: In 1986, 34 percent of people who smoked in the preceding year stopped for at least 1 day during that year)

3.7 Increase smoking cessation during pregnancy so that at least 60 percent of women who are cigarette smokers at the time they become pregnant quit smoking early in pregnancy and maintain abstinence for the remainder of their pregnancy. (Baseline: 39 percent of white women aged 20–44 quit at any time during pregnancy in 1985)

Special Population Target

	Cessation and Abstinence During Pregnancy	1985 Baseline	2000 Target
3.7a	Women with less than a high school education	28% [†]	45%

[†]Baseline for white women aged 20–44

3.8* Reduce to no more than 20 percent the proportion of children aged 6 and younger who are regularly exposed to tobacco smoke at home. (Baseline: More than 39 percent in 1986, as 39 percent of households with one or more children aged 6 or younger had a cigarette smoker in the household)

Note: Regular exposure to tobacco smoke at home is defined as the occurrence of tobacco smoking anywhere in the home on more than 3 days each week.

3.9 Reduce smokeless tobacco use by males aged 12–24 to a prevalence of no more than 4 percent. (Baseline: 6.6 percent among males aged 12–17 in 1988; 8.9 percent among males aged 18–24 in 1987)

Special Population Target

	Smokeless Tobacco Use	1986–87 Baseline	2000 Target
3.9a	American Indian/Alaska Natives aged 18–24	18–64%	10%

Note: For males aged 12–17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18–24, a smokeless tobacco user is someone who has used either snuff or chewing tobacco at least 20 times and who currently uses snuff or chewing tobacco.

Services and Protection Objectives

3.10 Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of comprehensive school health education. (Baseline: 17 percent of school districts totally banned smoking on school premises or at school functions in 1988; anti-smoking education was provided by 78 percent of school districts at the high school level, 81 percent at the middle school level, and 75 percent at the elementary school level in 1988)

3.11 Increase to 100 percent the proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace. (Baseline: 27 percent of worksites with 50 or more employees in 1985; 54 percent of medium and large companies in 1987)

3.12* Enact in 50 States and the District of Columbia comprehensive laws on clean indoor air that prohibit smoking or limit it to separately ventilated areas in the workplace and enclosed public places. (Baseline: 4 States regulated private workplaces; 8 States regulated public workplaces, including those that banned smoking through Executive Orders; 2 States regulated restaurants; 14 States and the District of Columbia regulated public transportation; 9 States regulated hospitals; 21 States regulated day care centers; and 6 States regulated grocery stores with comprehensive laws as of January 1995)

3.13 Enact in 50 States and the District of Columbia laws prohibiting the sale and distribution of tobacco products to youth younger than age 18. Enforce these laws so that the buy rate in compliance checks conducted in all 50 States and the District of Columbia is no higher than 20 percent. (Baseline: 44 States and the District of Columbia had, but rarely enforced, laws regulating the sale and/or distribution of cigarettes or tobacco products to minors in 1990; only 3 set the age of majority at 19. Baseline and followup data on enforcement will be provided in State reports to the Substance Abuse and Mental Health Services Administration as a part of compliance with the Synar amendment.)

Note: In July 1992, the President signed Public Law 102-321, the reorganization of the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, which included the "Synar Amendment." The new law requires all 50 States and the District of Columbia to ban the sale and distribution of tobacco products to everyone under the age of 18. It also required States to enforce their law "in a manner that can be reasonably be expected to reduce the extent to which tobacco products are available to underage youths" or risk the loss of a percentage of Federal Substance Abuse Prevention and Treatment Block Grants.

Although all States have enacted youth access laws, enforcement is variable. Therefore, this objective will separately report on the enactment and enforcement of youth access laws. Enforcement will be measured based on HHS regulations implementing the amendment.

Model legislation proposed by HHS recommends licensure of tobacco vendors, civil money penalties and license suspension or revocation for violations, and a ban on cigarette vending machines.

3.14 Establish in 50 States and the District of Columbia plans to reduce tobacco use, especially among youth. (Baseline: 12 States in 1989)

3.15 Eliminate or severely restrict all forms of tobacco product advertising and promotion to which youth younger than age 18 are likely to be exposed. (Baseline: Radio and television advertising of tobacco products were prohibited, but other restrictions on advertising and promotion to which youth may be exposed were minimal in 1990)

3.16 Increase to at least 75 percent the proportion of primary care and oral health care providers who routinely advise cessation and provide assistance and followup for all of their tobacco-using patients. (Baseline: About 52 percent of internists reported counseling more than 75 percent of their smoking patients about smoking cessation in 1986; about 35 percent of dentists reported counseling at least 75 percent of their smoking patients about smoking in 1986)

1995 Additions

Health Status Objectives

3.17* Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline: 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

3.18* Reduce stroke deaths to no more than 20 per 100,000 people (Age-adjusted baseline: 30.4 per 100,000 in 1987)

Special Population Target

	<i>Stroke Deaths (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
3.18a Blacks		52.5	27.0

Risk Reduction Objectives

3.19* Increase by at least 1 year the average age of first use of cigarettes, alcohol, and marijuana by adolescents aged 12–17. (Baseline: Age 11.6 for cigarettes, age 13.1 for alcohol, and age 13.4 for marijuana in 1988)

3.20* Reduce the proportion of young people who have used alcohol, marijuana, cocaine, or cigarettes in the past month as follows:

<i>Substance/Age</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
Alcohol/aged 12–17	25.2%	12.6%
Alcohol/aged 18–20	57.9%	29.0%
Marijuana/aged 12–17	6.4%	3.2%
Marijuana/aged 18–25	15.5%	7.8%
Cocaine/aged 12–17	1.1%	0.6%
Cocaine/aged 18–25	4.5%	2.3%

Appendix A: 1995 Summary List of Objectives

<i>Use in past month</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
<i>Alcohol</i>		
Hispanic 12–17 years	22.5%	12.0%
<i>Cocaine</i>		
Hispanic 12–17 years	1.3%	0.6%
Hispanic 18–25 years	2.7%	1.0%
<i>Cigarettes</i>		
12–17 years	10.8%	6.0%

Note: The targets of this objective are consistent with the goals established by the Office of National Drug Control Policy, Executive Office of the President.

3.21* Increase the proportion of high school seniors who perceive social disapproval of heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of cigarettes, as follows:

<i>Behavior</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
Heavy use of alcohol	56.4%	70%
Occasional use of marijuana	71.1%	85%
Trying cocaine once or twice	88.9%	95%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

<i>Behavior</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
Smoking one or more pack of cigarettes per day	74.2%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

3.22* Increase the proportion of high school seniors who associate physical or psychological harm with heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of tobacco, as follows:

<i>Behavior</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
Heavy use of alcohol	44.0%	70%
Regular use of marijuana	77.5%	90%
Trying cocaine once or twice	54.9%	80%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

<i>Behavior</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
Smoking one or more packs of cigarettes per day	68.6%	95%
Using smokeless tobacco regularly	37.4%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

Services and Protection Objectives

3.23 Increase the average (State and Federal combined) tobacco excise tax to at least 50 percent of the average retail price of all cigarettes and smokeless tobacco.

<i>Tax as a Percent of Retail Price (State and Federal)</i>	<i>1993 Baseline</i>	<i>2000 Target</i>
Cigarettes	31.4%	50%
Smokeless Tobacco	11.8%	50%

Source: "The Tax Burden on Tobacco," *The Tobacco Institute, 1994* and CDC, *Office on Smoking and Health*.

Commentary:

Cigarettes

Enacting increases in taxes on tobacco products is good health policy. Changes in price can have a dramatic impact on the levels of tobacco consumption and tobacco use prevalence among youth and adults. Price increases will encourage smoking cessation among current smokers and discourage smoking initiation among youth, preventing millions of premature deaths and saving millions in health care costs. A panel convened by the National Cancer Institute (NCI) in 1991 reviewed the role of excise taxes as a deterrent to smoking. In the summary report, the expert panel concluded that excise taxes may be the single most effective approach to reducing tobacco use by youth. The panel stated that youth consumption would decrease in response to increased prices at a rate of at least 3–5 percent for every 10 percent increase in the price, a rate equal to the decline in tobacco use among adults. In addition, the panel concluded that youth price sensitivity may be as high as 3 times the adult rates, although the data on this were inconclusive.¹

Tax incidence reflects the average State and Federal tax on a pack of cigarettes as a proportion of the average retail price of a pack of cigarettes. From the mid-1950s through the early 1970s the State and Federal cigarette tax incidence was over 46 percent, with a high of 51.4 percent in 1965. By 1987, the tax incidence had dropped to 28.8 percent. Furthermore, the U.S. cigarette tax incidence is considerably lower than that for many industrialized nations. The average tax incidence across 23 developed nations is 68.5 percent. By the year 2000, the United States should be taxing tobacco products consistent with historic levels in the United States.

The Federal excise tax on cigarettes is currently 24 cents per pack, having been raised from 20 to 24 cents in 1993 as part of the Budget Reconciliation Act of 1990. In addition to the Federal tax, all States, the District of Columbia, 369 towns, and 20 counties currently impose excise taxes on cigarettes. As of September 30, 1994, State excise taxes ranged from 2.5 cents per pack in Virginia to 75 cents per pack in Michigan and averaged 30.5 cents per pack.²

In real terms, the Federal excise tax on cigarettes decreased by 68 percent from 1964 to 1982, and the average State tax on cigarettes declined by more than 40 percent

from 1975 to 1990. To serve as an effective deterrent over time, excise taxes on tobacco products should be restructured from unit taxes on cigarettes and other tobacco products to equivalent-yield *ad valorem* taxes, which would allow revenues to keep pace with inflation-induced increases in product prices.³

Excise tax increases offer the added benefit of generating public revenue with relatively low administrative costs. A portion of the funds could be earmarked for tobacco use prevention programs to further deter tobacco use by youth. In 1988 California voters passed Proposition 99, which increased the State excise tax on tobacco by 25 cents per pack. Some of the revenue derived from this increase was earmarked for tobacco use prevention and reduction programs. The combination of a tax increase and a comprehensive tobacco control program reduced per capita consumption by 17 percent from January 1989 through January 1991.⁴ Additional economic research has demonstrated that the tax increase had an impact on the decline in consumption independent of the impact of the comprehensive tobacco control program.⁵

Most public opinion polls and surveys indicate that at least 75 percent of the American public supports an increase in the current excise tax on tobacco. A 1993 Gallup poll, which surveyed smoker and nonsmoker support, found that 40 percent of smokers and 85 percent of nonsmokers favored a tobacco excise tax increase to finance national health reform.⁶ A 1993 poll conducted by the American Cancer Society (ACS) found strong support (66 percent) for a significant tobacco tax increase (2 dollars) to support a national health plan. This support was broad-based demographically, with 64 percent of African Americans supporting a 2 dollar increase and 71 percent of Hispanic Americans supporting the increase.⁷

Smokeless Tobacco Products

Smokeless tobacco products are highly addictive and are not safe alternatives to smoking. Moist snuff (dip) and chewing tobacco (chew) are the dominant forms of smokeless tobacco. The standard unit for retail purchase for snuff is a 1.2 ounce tin; and for chew, a 3-ounce pouch. A typical dose of snuff contains two to three times the amount of nicotine in a single cigarette.

The Federal excise tax on smokeless tobacco products is 36 cents per pound for snuff and 12 cents per pound for chewing tobacco; this translates into 2.7 cents per can for snuff and 2.3 cents per package of chewing tobacco. These taxes are considerably less than the 24 cents per pack of cigarettes. State taxes on smokeless tobacco products vary greatly. As of September 30, 1994, 9 States and the District of Columbia had no tax on smokeless tobacco products.

Smokeless tobacco is taxed at about one-tenth the rate of cigarettes. The tax discrepancy between cigarettes and smokeless tobacco may encourage children to start using smokeless tobacco as an alternative to smoking or may encourage the substitution of smokeless tobacco for cigarettes among young people who already smoke.⁸

Among high school seniors who have ever used smokeless tobacco, 73 percent did so by the ninth grade.⁹

The American Public Health Association, the American Dental Association, and the Association of State and Territorial Dental Directors have recommended that taxes on smokeless tobacco products be at least equal to those on cigarettes. In addition, the Association of Public Health Dentistry has supported significant increases in excise taxes on tobacco products. Failure to equalize the tax may result in many smokers switching from cigarettes to smokeless tobacco and many youngsters who would not smoke taking up smokeless tobacco instead.

3.24 Increase to 100 percent the proportion of health plans that offer treatment of nicotine addiction (e.g., tobacco use cessation counseling by health care providers, tobacco use cessation classes, prescriptions for nicotine replacement therapies, and/or other cessation services). (Baseline: 11 percent of health plans cover treatment for nicotine addiction in 1985)

Source: Gelb, B.D. *Preventive Medicine and Employee Productivity*. Harvard Business Review 64(2):12. 1985.¹⁰

Commentary:

Extensive evidence suggests that treatment of nicotine addiction substantially reduces morbidity and mortality due to tobacco-related diseases. In the 1988 report, *The Health Consequences of Smoking: Nicotine Addiction*, the Surgeon General asserted that treatment of nicotine addiction should be more widely available and that it should be considered at least as favorably by third-party payers as treatment of alcoholism and illicit drug addiction.¹¹ Furthermore, the U.S. Preventive Services Task Force has recommended that smoking cessation counseling be reimbursed by third-party payers.¹²

This new objective seeks to ensure that no tobacco user has financial barriers to seeking effective treatment for their nicotine addiction.

More than 70 percent of U.S. smokers see their physician each year, giving physicians considerable access to smokers.¹³ In addition, dentists see over 60 percent of the U.S. population aged 5 and older within 1 year.¹⁴ Clinical trials have demonstrated that physicians and dentists can help their patients stop smoking.¹⁵ If only half of all U.S. physicians and dentists gave brief advice to their patients and were successful with only 10 percent of them, there would still be more than 2 million new nonsmokers in the United States each year.¹³ The National Cancer Institute has developed manuals for physicians and dentists to assist patients to quit smoking.^{13,16} The National Heart, Lung, and Blood Institute has produced a similar manual for nurses.¹⁷

It has been estimated that cessation counseling is more cost effective than beta-adrenergic antagonist therapy after a myocardial infarction.¹⁸ Other studies have

shown that physician counseling against smoking is at least as cost effective as several other preventive medical practices, including treatment of mild or moderate hypertension or high cholesterol.¹⁹

Cessation rates improve as the intensity of the intervention increases. Greater cessation rates have been achieved with counseling by health care providers compared to providing advice alone. Even higher rates have been achieved with counseling combined with nicotine replacement therapy. Support for the maintenance of cessation is critical to long-term success.

3.25* Reduce to zero the number of States that have clean indoor air laws preempting stronger clean indoor air laws on the local level. (Baseline: 17 States had preemptive clean indoor air laws as of January 1995)

Source: Legislative Tracking System, CDC, and State Cancer Legislative Database, NCI

Commentary:

Preemptive State tobacco control laws prevent local jurisdictions from enacting more stringent restrictions than the State law, enacting restrictions varying from the State law, or enacting related restrictions. Although the tobacco industry attempts to promote such laws as health promotion efforts to ensure a minimum uniform set of restriction for all communities, such laws usually afford less protection and prevent local governments from adopting more restrictive provisions in the future.²⁰

Consequences of preemptive laws have included weaker public health standards, loss of community education involved in the passage of local ordinances; more difficulty with enforcement at the local level; and lower compliance with the laws.²¹

Several national organizations have expressed opposition to the enactment of preemptive laws including the American Public Health Association, the Institute of Medicine, and a working group of State Attorneys General.

3.26 Enact in 50 States and the District of Columbia laws banning cigarette vending machines except in places inaccessible to minors. (Baseline: 12 States and the District of Columbia as of January 1995)

Source: Legislative Tracking System, CDC

Commentary:

There are an estimated 3 million underage smokers in the United States. They purchase 947 million packs of cigarettes and 26 million cans of smokeless tobacco each year, resulting in \$1.26 billion in tobacco sales.²² A 1992 study by the CDC concluded that more than half of underage smokers buy their own cigarettes.²³ Although studies also show that only 23 percent of smoking youth now use vending machines often or occasionally, anticipated changes in State enforcement of minors' access laws may increase the number of underage smokers who use tobacco vending machines.

Vending machines suggest a universal availability of cigarettes in our society. They provide an easy source of tobacco for the youngest underage smokers. A study concluded that most teens (56 percent) say they use vending machines "because no one will stop me from buying cigarettes this way."²⁴ This same study found that 60 percent of teenage smokers who buy their own cigarettes have ever been refused when they were trying to buy them. Of these, virtually all (98 percent) had been stopped from buying cigarettes over the counter, but only about 1 in 10 had ever been stopped from buying cigarettes from a vending machine.²⁴ Furthermore, because vending machines are self-service, it is difficult to attach responsibility and liability to a particular individual for illegal sales to minors from vending machines, and sales personnel at a register cannot effectively supervise even nearby machines while serving other customers.

Selling candy and cigarettes from the same vending machine, and unrestricted accessibility to tobacco vending machines encourages and facilitates cigarette sales to minors. Although all States have enacted laws prohibiting the purchase of tobacco products under the age of 18, few States have strong vending machine restrictions.

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Substance Abuse: Alcohol and Other Drugs

Health Status Objectives

4.1* Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 5.5 per 100,000 people. (Age-adjusted baseline: 9.8 per 100,000 in 1987)

Special Population Targets

	<i>Alcohol-Related Motor Vehicle Crash Deaths (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
4.1a	American Indian/Alaska Native men	40.4	35.0
4.1b	People aged 15–24	21.5	12.5

4.2 Reduce cirrhosis deaths to no more than 6 per 100,000 people. (Age-adjusted baseline: 9.2 per 100,000 in 1987)

Special Population Targets

	<i>Cirrhosis Deaths (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
4.2a	Black men	22.6	12
4.2b	American Indians/Alaska Natives	20.5	10
4.2c	Hispanics	<i>1990 Baseline</i> 14.0	<i>2000 Target</i> 10

4.3 Reduce drug-related deaths to no more than 3 per 100,000 people. (Age-adjusted baseline: 3.8 per 100,000 in 1987)

Special Population Targets

	<i>Drug-Related Deaths (per 100,000)</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
4.3a	Blacks	5.7	3
4.3b	Hispanics	4.3	3

4.4 Reduce drug abuse-related hospital emergency department visits by at least 20 percent. (Baseline: 175.8 per 100,000 people in 1991)

Risk Reduction Objectives

4.5* Increase by at least 1 year the average age of first use of cigarettes, alcohol, and marijuana by adolescents aged 12–17. (Baseline: Age 11.6 for cigarettes, age 13.1 for alcohol, and age 13.4 for marijuana in 1988)

4.6* Reduce the proportion of young people who have used alcohol, marijuana, cocaine, or cigarettes in the past month as follows:

<i>Substance/Age</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
Alcohol/aged 12–17	25.2%	12.6%
Alcohol/aged 18–20	57.9%	29.0%
Marijuana/aged 12–17	6.4%	3.2%
Marijuana/aged 18–25	15.5%	7.8%
Cocaine/aged 12–17	1.1%	0.6%
Cocaine/aged 18–25	4.5%	2.3%

Appendix A: 1995 Summary List of Objectives

<i>Use in Past Month</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
<i>Alcohol</i>		
Hispanic 12–17 years	22.5%	12.0%
<i>Cocaine</i>		
Hispanic 12–17 years	1.3%	0.6%
Hispanic 18–25 years	2.7%	1.0%
<i>Cigarettes</i>		
12–17 years	10.8%	6.0%

Note: The targets of this objective are consistent with the goals established by the Office of National Drug Control Policy, Executive Office of the President.

4.7 Reduce the proportion of high school seniors and college students engaging in recent occasions of heavy drinking of alcoholic beverages to no more than 28 percent of high school seniors and 32 percent of college students. (Baseline: 33 percent of high school seniors and 41.7 percent of college students in 1989)

Note: Recent heavy drinking is defined as having five or more drinks on one occasion in the previous 2-week period as monitored by self-reports.

4.8 Reduce alcohol consumption by people aged 14 and older to an annual average of no more than 2 gallons of ethanol per person. (Baseline: 2.54 gallons of ethanol in 1987)

4.9* Increase the proportion of high school seniors who perceive social disapproval of heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of tobacco, as follows:

<i>Behavior</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
Heavy use of alcohol	56.4%	70%
Occasional use of marijuana	71.1%	85%
Trying cocaine once or twice	88.9%	95%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

<i>Behavior</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
Smoking one or more pack of cigarettes per day	74.2%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

4.10* Increase the proportion of high school seniors who associate physical or psychological harm with heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of cigarettes, as follows:

<i>Behavior</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
Heavy use of alcohol	44.0%	70%
Regular use of marijuana	77.5%	90%
Trying cocaine once or twice	54.9%	80%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

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<i>Behavior</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
Smoking one or more packs of cigarettes per day	68.6%	95%
Using smokeless tobacco regularly	37.4%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

4.11 Reduce to no more than 3 percent the proportion of male high school seniors who use anabolic steroids. (Baseline: 4.7 percent in 1989)

Services and Protection Objectives

4.12 Establish and monitor in 50 States comprehensive plans to ensure access to alcohol and drug treatment programs for traditionally underserved people. (Baseline data unavailable)

4.13 Provide to children in all school districts and private schools primary and secondary school educational programs on alcohol and other drugs, preferably as part of comprehensive school health education. (Baseline: 63 percent provided some instruction, 39 percent provided counseling, and 23 percent referred students for clinical assessments in 1987)

4.14 Extend adoption of alcohol and drug policies for the work environment to at least 60 percent of worksites with 50 or more employees. (Baseline: 88 percent of worksites had adopted alcohol policies; 89 percent of worksites had adopted drug policies in 1992)

4.15 Extend to 50 States administrative driver's license suspension/revocation laws or programs of equal effectiveness for people determined to have been driving under the influence of intoxicants. (Baseline: 28 States and the District of Columbia in 1990)

4.16 Increase to 50 the number of States that have enacted and enforce policies, beyond those in existence in 1989, to reduce access to alcoholic beverages by minors. (Baseline data unavailable)

Note: Policies to reduce access to alcoholic beverages by minors may include those that address restriction of the sale of alcoholic beverages at recreational and entertainment events at which youth make up a majority of participants/consumers, product pricing, penalties and license revocation for sale of alcoholic beverages to minors, and other approaches designed to discourage and restrict purchase of alcoholic beverages by minors.

4.17 Increase to at least 20 the number of States that have enacted statutes to restrict promotion of alcoholic beverages that is focused principally on young audiences. (Baseline data unavailable)

4.18 Extend to 50 States legal blood alcohol concentration tolerance levels of .08 percent for motor vehicle drivers aged 21 and older and zero tolerance (.02 percent and lower) for those younger than age 21. (Baseline: 7 States with .08 BAC laws and 9 States with zero tolerance laws in 1993)

Note: The legal blood alcohol concentration tolerance level for adults was revised to be consistent with the goals established by the National Highway Traffic Safety Administration.

4.19 Increase to at least 75 percent the proportion of primary care providers who screen for alcohol and other drug use problems and provide counseling and referral as needed. (Baseline: 19–63 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

1995 Addition

Services and Protection Objective

4.20 Increase to 30 the number of States with Hospitality Resource Panels (including representatives from State regulatory, public health, and highway safety agencies, law enforcement, insurance associations, alcohol retail and licensed beverage associations) to ensure a process of management and server training and define standards of responsible hospitality. (Baseline: 8 States in 1994)

Source: California Coordinating Council on Responsible Beverage Service, National Survey Report

Commentary:

The primary purpose of this objective is to build upon voluntary models of management and server training. By establishing Hospitality Resource Panels that are broadly representative of the community—alcohol industry, insurance associations, State regulatory, public health, highway safety, and law enforcement agencies—a partnership can be formed to promote responsible drinking. Prevention goals that focus on voluntary standards for management and server training can be an effective prevention strategy with the potential to reduce alcohol-related injuries. While some States do mandate training in the hospitality industry, other States have increased incentives through public recognition and reduced liability to achieve its public health objectives.

A recent study of the research on responsible beverage service by A. James McKnight¹ concludes that server training can change attitudes and knowledge but does not change behavior as much as enforcement of alcohol regulation and strong policies and commitments to responsible service from the managers of public drinking establishments. This research underscores the importance of having members of the hospitality industry working with public health and highway safety agencies on Hospitality Resource Panels.

Training managers and servers in the hospitality industry to address issues such as service to minors and intoxicated persons can, from a public health standpoint, reduce harm to society. It encourages server intervention which can be a forceful deterrent to irresponsible drinking practices and contributes to the prevention of alcohol-related injuries.

A recent analysis of the role of management and server training is described in the following:

Only when a community recognizes the problems resulting from irresponsible alcohol service and is prepared to take action at the community-wide level can an effective program be launched. Such a program would include strong enforcement of alcohol control laws, strong policies on and commitments to responsible service from the managers of public drinking establishments, and server training.²

References

1. McKnight, A.J. Server Intervention: Accomplishment and Needs. *Alcohol Health and Research World* 17(1):76-83. 1993.
2. Mosher, J.F. and Colman, V.J. The Model Dram Shop Act of 1985. *Alcohol Health and Research World* 10(4):4-11. 1986.

Family Planning

Health Status Objectives

5.1 Reduce pregnancies among females aged 15–17 to no more than 50 per 1,000 adolescents. (Baseline: 71.1 pregnancies per 1,000 females aged 15–17 in 1985)

Special Population Targets

	<i>Pregnancies (per 1,000)</i>	<i>1985 Baseline</i>	<i>2000 Target</i>
5.1a	Black adolescent females aged 15–19	169	120
5.1b	Hispanic adolescent females aged 15–19	143	105

Note: For black and Hispanic adolescent females, baseline data are unavailable for those aged 15–17. The targets for these two populations are based on data for females aged 15–19. If more complete data become available, a 35-percent reduction from baseline figures should be used as the target.

5.2 Reduce to no more than 30 percent the proportion of all pregnancies that are unintended. (Baseline: 56 percent of pregnancies in the previous 5 years were unintended, either unwanted or earlier than desired, in 1988)

Special Population Targets

	<i>Unintended Pregnancies</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
5.2a	Black females	78.0%	40%
5.2b	Hispanic females	54.9%	30%

5.3 Reduce the prevalence of infertility to no more than 6.5 percent. (Baseline: 7.9 percent of married couples with wives aged 15–44 in 1988)

Special Population Targets

	<i>Prevalence of Infertility</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
5.3a	Black couples	12.1%	9%
5.3b	Hispanic couples	12.4%	9%

Note: Infertility is the failure of couples to conceive after 12 months of intercourse without contraception.

Risk Reduction Objectives

5.4* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17; reported in 1988)

Special Population Targets

	<i>Adolescents Engaged in Sexual Intercourse</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
5.4a	Black males aged 15	69%	15%
5.4b	Black males aged 17	90%	40%
5.4c	Black females aged 17	66%	40%

5.5* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse during the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 in 1988 and 33 percent of sexually active males aged 15–17 in 1988)

5.6 Increase to at least 90 percent the proportion of sexually active, unmarried people aged 15–24 who use contraception, especially combined method contraception that both effectively prevents pregnancy and provides barrier protection against disease. (Baseline: 78 percent at most recent intercourse and 63 percent at first intercourse; 2 percent used oral contraceptives and the condom at most recent intercourse; among young women aged 15–19 in 1988)

5.7 Increase the effectiveness with which family planning methods are used, as measured by a decrease to no more than 7 percent in the proportion of women experiencing pregnancy despite use of a contraceptive method. (Baseline: Approximately 14 percent of women using reversible contraceptive methods experienced an unintended pregnancy in 1988)

Special Population Targets

	<i>Percent of Users Who Became Pregnant In the Last Year</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
5.7a	Black females	17.6%	8%
5.7b	Hispanic females	16.4%	8%

Services and Protection Objectives

5.8 Increase to at least 85 percent the proportion of people aged 10–18 who have discussed human sexuality, including correct anatomical names, sexual abuse, and values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school, or religious programs. (Baseline: 66 percent of people aged 13–18 have discussed sexuality with their parents; reported in 1986)

5.9 Increase to at least 90 percent the proportion of family planning counselors who offer accurate information about all options, including prenatal care and delivery, infant care, foster care, or adoption and pregnancy termination to their patients with unintended pregnancies. (Baseline: 60 percent in 1984)

5.10* Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline: 18–65 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

5.11* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that provide on site primary prevention and provide or refer for secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

1995 Addition

Risk Reduction Objective

5.12 Increase to at least 95 percent the proportion of all females aged 15–44 at risk of unintended pregnancy who use contraception. (Baseline: 88.2 percent of all females aged 15–44 in 1982)

		<i>Special Population Targets</i>		
<i>Percent Using Contraception Among Females Aged 15–44 at Risk of Unintended Pregnancy</i>		<i>1982 Baseline</i>	<i>1988</i>	<i>2000 Target</i>
5.12a	Black females	78.9%	84.7%	95%
5.12b	Females with income less than 100 percent of poverty	79.6%	80.2%	95%
5.12c	Females aged 15–19 under 200 percent poverty	67.4%	74.9%	95%

Source: Forrest, J.D. and Singh, S. *The sexual and reproductive behavior of American women, 1982–1988*. Family Planning Perspectives 22(5):206–14. 1990; also unpublished tabulations of the 1982 and 1988 National Survey of Family Growth, CDC.

Commentary:

Females at risk of unintended pregnancy are those who are fecund and who are sexually active but do not wish to have a child in the near future. This group includes females who are protected by contraception and those who are not using any method at all. In 1982, 63 percent of all females aged 15–44 were considered to be at risk of unintended pregnancy, compared to 67 percent in 1988. The proportion not using any method was approximately 10 percent in 1988, compared to 12 percent in 1982. However, even this apparently small proportion is an important group, since in absolute numbers this was about 4 million females in 1988. This group of women accounts for a large part of the need for women to resort to abortion. The proportion

not using a method of contraception is even higher among some subgroups; poor females are much more likely to be using no method of contraception, and among poor teenagers this proportion reaches 25 percent.

In 1988, 90.1 percent of all females who were at risk of unintended pregnancy used contraception. However, only 85.3 percent of females whose income fell below 200 percent of the poverty line and only 80.2 percent of the poorest females—below 100 percent of the poverty line—used contraception in 1988. Thus nearly 20 percent of the Nation's lowest income females at risk of unintended pregnancy used no form of contraception to protect themselves against unintended pregnancy.

This objective is aimed at increasing the proportion of all females who are at risk of unintended pregnancy who are protected by contraception to 95 percent, and to reduce differences between income groups. Among low-income females at risk of unintended pregnancy in 1988:

- 23 percent (nearly one out of four) of low-income females at risk of unintended pregnancy who used contraception depended on publicly funded family planning providers for their contraception;
- only 16.5 percent went to a private provider;
- 31.5 percent relied on sterilization;
- 14.5 percent relied on methods that do not require medical intervention; and
- 15 percent were in need of family planning services and not getting them.

With regard to international comparisons of contraceptive use, nationally representative survey data on contraceptive use is not collected as regularly in other developed countries as it is in the United States. More importantly, the data that are available do not use the concept of women at risk as it is defined in the United States. As a result, exactly comparable data are not available. However, comparable data for the early 1980s for several developed countries does show that among married or cohabiting women aged 20–29 and 35–44, use of any method was somewhat lower in the United States than in some developed countries. In the United States, 68 percent of married or cohabiting women aged 20–29 used a method, compared to 76 percent in Greece and the Netherlands, 73–74 percent in Finland, France, Norway, and Portugal, and 72 percent in Italy and the United Kingdom. Even larger differences exist among women aged 35–44, with about 63 percent of this group using a method in the United States, compared to 75–83 percent in a number of European countries, including all of those listed above, as well as some others.¹

Reference

1. Jones, E., et al. *Pregnancy, Contraception and Family Planning Services in Industrialized Countries*, Yale University Press, 1988.

Mental Health and Mental Disorders

Health Status Objectives

6.1* Reduce suicides to no more than 10.5 per 100,000 people. (Age-adjusted baseline: 11.7 per 100,000 in 1987)

Special Population Targets

	Suicides (per 100,000)	1987 Baseline	2000 Target
6.1a	Youth aged 15–19	10.2	8.2
6.1b	Men aged 20–34	25.2	21.4
6.1c	White men aged 65 and older	46.7	39.2
6.1d	American Indian/ Alaska Native men	20.1	17.0

6.2* Reduce to 1.8 percent the incidence of injurious suicide attempts among adolescents aged 14–17. (Baseline: 2.1 percent in 1990)

Special Population Target

	Injurious Suicide Attempts	1991 Baseline	2000 Target
6.2a	Female adolescents aged 14–17	2.5	2.0

Note: Data are limited to those suicide attempts that result in hospitalization and are based on self-reports.

6.3 Reduce to less than 17 percent the prevalence of mental disorders among children and adolescents. (Baseline: An estimated 20 percent among youth younger than age 18 in 1992)

Note: The baseline has been revised based on Bird, H.R., et al., Estimates of the Prevalence of Childhood Maladjustment in a Community Survey in Puerto Rico, 1988, and Costello, E.J., et al., "Psychiatric Disorders in Pediatric Primary Care: Prevalence Risk Factors," 1988; in Archives of General Psychiatry, Vol. 45. The ongoing data source will be the Multi-site Study of Service, Use, Need, Outcomes and Costs for Child and Adolescent Populations (UNO-CAP), NIH. The baseline revision has resulted in a year 2000 target revision.

6.4 Reduce the prevalence of mental disorders (exclusive of substance abuse) among adults living in the community to less than 10.7 percent. (Baseline: 1-month point prevalence of 12.6 percent in 1984)

6.5 Reduce to less than 35 percent the proportion of people aged 18 and older who report adverse health effects from stress within the past year. (Baseline: 44.2 percent in 1985)

Special Population Target

	1985 Baseline	2000 Target
6.5a	People with disabilities	53.5% 40%

Note: For this objective, people with disabilities are people who report any limitation in activity due to chronic conditions.

Risk Reduction Objectives

6.6 Increase to at least 30 percent the proportion of people aged 18 and older with severe, persistent mental disorders who use community support programs. (Baseline: 15 percent in 1986)

6.7 Increase to at least 54 percent the proportion of people with major depressive disorders who obtain treatment. (Baseline: 31 percent in 1982)

6.8 Increase to at least 20 percent the proportion of people aged 18 and older who seek help in coping with personal and emotional problems. (Baseline: 11.1 percent in 1985)

Special Population Target

	<i>1985 Baseline</i>	<i>2000 Target</i>
6.8a People with disabilities	14.7%	30%

6.9 Decrease to no more than 5 percent the proportion of people aged 18 and older who report experiencing significant levels of stress who do not take steps to reduce or control their stress. (Baseline: 24 percent in 1985)

Services and Protection Objectives

6.10* Increase to 50 the number of States with officially established protocols that engage mental health, alcohol and drug, and public health authorities with corrections authorities to facilitate identification and appropriate intervention to prevent suicide by jail inmates. (Baseline: 3 States in 1992)

6.11 Increase to at least 40 percent the proportion of worksites employing 50 or more people that provide programs to reduce employee stress. (Baseline: 26.6 percent in 1985)

6.12 Establish a network to facilitate access to mutual self-help activities, resources, and information by people and their family members who are experiencing emotional distress resulting from mental or physical illness. (Baseline: 2 Federal and 8 State clearinghouses in 1995)

6.13 Increase to at least 60 percent the proportion of primary care providers who routinely review with patients their patients' cognitive, emotional, and behavioral functioning and the resources available to deal with any problems that are identified. (Baseline: 7–40 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

6.14 Increase to at least 75 percent the proportion of providers of primary care for children who include assessment of cognitive, emotional, and parent-child functioning, with appropriate counseling, referral, and followup, in their clinical practices. (Baseline: 24–62 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, and family physicians reported routinely providing services to patients in 1992)

1995 Addition

Health Status Objective

6.15 Reduce the prevalence of depressive (affective) disorders among adults living in the community to less than 4.3 percent. (Baseline: 1 month prevalence of 5.1 percent in 1984)

Special Population Target

	<i>Depressive Disorders</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
6.15a	Women	6.6%	5.5%

Source: Baseline: Epidemiologic Catchment Area Study, NIH, 1981–1985. Ongoing Source: National Comorbidity Survey, NIH.

Commentary:

Depression is a highly prevalent disorder, particularly among women. Research shows that depression is often comorbid with other psychiatric and physical illnesses. There is a high correlation between depression and attempted and completed suicides. Primary care physicians often fail to recognize the symptoms of depression in their patients, and the symptoms of depression often mimic those of physical illnesses. Depression is a significant public health problem that can be effectively treated. Approximately 80 percent of patients can be successfully treated, yet less than 40 percent of individuals with depression are treated by a health care provider. Particularly disturbing is the high rate of affective disorders among females. The rate for females is 6.6 percent which is nearly twice that of males—3.5 percent. The overall rate is 5.1 percent.

There were two large population surveys in which trained interviewers collected information on clinical diagnosis: The Epidemiologic Catchment Area Study (conducted in the early 1980s) and the National Comorbidity Survey (conducted in the early 1990s).

Violent and Abusive Behavior

Health Status Objectives

7.1 Reduce homicides to no more than 7.2 per 100,000 people. (Age-adjusted baseline: 8.5 per 100,000 in 1987)

Special Population Targets

	Homicide Rate (per 100,000)	1987 Baseline	2000 Target
7.1a	Children aged 3 and younger	3.9	3.1
7.1b	Spouses aged 15–34	1.7	1.4
7.1c	Black men aged 15–34	91.1	72.4
7.1d	Hispanic men aged 15–34	41.3	33.0
7.1e	Black women aged 15–34	20.2	16.0
7.1f	American Indians/Alaska Natives	11.2	9.0

7.2* Reduce suicides to no more than 10.5 per 100,000 people. (Age-adjusted baseline: 11.7 per 100,000 in 1987)

Special Population Targets

	Suicides (per 100,000)	1987 Baseline	2000 Target
7.2a	Youth aged 15–19	10.2	8.2
7.2b	Men aged 20–34	25.2	21.4
7.2c	White men aged 65 and older	46.7	39.2
7.2d	American Indian/Alaska Native men	20.1	17.0

7.3 Reduce firearm-related deaths to no more than 11.6 per 100,000 people from major causes. (Baseline: 14.6 firearm-related deaths in 1990)

Special Population Target

	Firearm-Related Deaths (per 100,000)	1990 Baseline	2000 Target
7.3a	Blacks	33.4	30.0

7.4 Reverse to less than 22.6 per 1,000 children the rising incidence of maltreatment of children younger than age 18. (Baseline: 22.6 per 1,000 in 1986)

Type-Specific Targets

	Incidence of Types of Maltreatment (per 1,000)	1986 Baseline	2000 Target
7.4a	Physical abuse	4.9	<4.9
7.4b	Sexual abuse	2.1	<2.1
7.4c	Emotional abuse	3.0	<3.0
7.4d	Neglect	14.6	<14.6

7.5 Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples. (Baseline: 30 per 1,000 in 1985)

Appendix A: 1995 Summary List of Objectives

7.6 Reduce assault injuries among people aged 12 and older to no more than 8.7 per 1,000 people. (Baseline: 9.7 per 1,000 in 1986)

7.7 Reduce rape and attempted rape of women aged 12 and older to no more than 108 per 100,000 women. (Baseline: 120 per 100,000 in 1986)

Special Population Target

	<i>Incidence of Rape and Attempted Rape (per 100,000)</i>	<i>1986 Baseline</i>	<i>2000 Target</i>
7.7a Women aged 12–34		250	225

7.8* Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14–17. (Baseline: 2.1 percent in 1991)

Special Population Target

	<i>Injurious Suicide Attempts</i>	<i>1986 Baseline</i>	<i>2000 Target</i>
7.8a Female Adolescents aged 14–17		2.5%	2.0%

Note: Data are limited to those suicide attempts that result in hospitalization and are based on self-reports.

Risk Reduction Objectives

7.9 Reduce to 110 per 1,000 the incidence of physical fighting among adolescents aged 14–17. (Baseline: 137 incidents per 1,000 high school students per month in 1991)

Special Population Target

	<i>Adolescent Physical Fighting (per 1,000)</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
7.9a Black males		207	160

7.10 Reduce to 86 per 1,000 the incidence of weapon-carrying by adolescents aged 14–17. (Baseline: 107 incidents per 1,000 high school students per month in 1991)

Special Population Target

	<i>Adolescent Weapon-Carrying (per 1,000)</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
7.10a Blacks		134	105

7.11 Reduce by 20 percent the proportion of people who possess weapons that are inappropriately stored and therefore dangerously available. (Baseline data unavailable)

Services and Protection Objectives

7.12 Extend protocols for routinely identifying, treating, and properly referring suicide attempters, victims of sexual assault, and victims of spouse, elder, and child abuse to at least 90 percent of hospital emergency departments. (Baseline data unavailable)

7.13 Extend to at least 45 States implementation of unexplained child death review systems. (Baseline: 33 States in 1991)

7.14 Increase to at least 30 the number of States in which at least 50 percent of children identified as neglected or physically or sexually abused receive physical and mental evaluation with appropriate followup as a means of breaking the intergenerational cycle of abuse. (Baseline data unavailable)

7.15 Reduce to less than 10 percent the proportion of battered women and their children turned away from emergency housing due to lack of space. (Baseline: 40 percent in 1987)

7.16 Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of comprehensive school health education. (Baseline data unavailable)

7.17 Extend coordinated, comprehensive violence prevention programs to at least 80 percent of local jurisdictions with populations over 100,000. (Baseline data unavailable)

7.18* Increase to 50 the number of States with officially established protocols that engage mental health, alcohol and drug, and public health authorities with corrections authorities to facilitate identification and appropriate intervention to prevent suicide by jail inmates. (Baseline: 3 States in 1992)

1995 Addition

Services and Protection Objective

7.19* Enact in 50 States and the District of Columbia laws requiring that firearms be properly stored to minimize access and the likelihood of discharge by minors. (Baseline: zero States in 1993)

Source: Center to Prevent Handgun Violence

Commentary:

In 1988, approximately 1,500 people were killed in the United States by the accidental discharge of firearms, and many more sustained injuries. Firearms were the fourth leading cause of unintentional injury deaths among children aged 5–14 and the third leading cause of unintentional injury deaths among 15- to 24-year olds. Guns that are accessible to children in unsupervised settings may produce fatal or serious injury. Adult caretakers must be educated about the need to protect minors from firearms, while laws must be enacted to highlight this need and provide enforcement measures. Although storing unloaded guns in locked boxes will minimize access by children, approaches such as trigger locks, childproof safety catches, and loading indicators should be explored as viable ways to reduce unintentional firearm-related deaths.

Appendix A: 1995 Summary List of Objectives

Firearm-related deaths account for the majority of recent increases in youth suicide and homicide. A distinction is made between supervised sport shooting settings and unsupervised youth with access to guns in high-risk settings, such as home, school, and streets.

This new objective also appears in Unintentional Injuries.

Educational and Community-Based Programs

Health Status Objectives

8.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	1990 Baseline	2000 Target
8.1a	Blacks	56.0	60
8.1b	Hispanics	64.8	65
8.1c	People aged 65 and older	11.9 [†]	14 [†]

[†]Years of healthy life remaining at age 65

Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure.

Risk Reduction Objectives

8.2 Increase the high school completion rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health. (Baseline: 87 percent of adults aged 19–20 in 1992)

Note: This objective and its target are consistent with the National Education Goal to increase high school graduation rates. The National Education Goal, the same measure and data source, is used to track this objective.

Special Population Targets

	Completion of High School	1992 Baseline	2000 Target
8.2a	Hispanics	65%	90%
8.2b	Blacks	81%	90%

Services and Protection Objectives

8.3 Achieve for all disadvantaged children and children with disabilities access to high quality and developmentally appropriate preschool programs that help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health. (Baseline: 47 percent of eligible children aged 4 were afforded the opportunity to enroll in Head Start in 1990)

Note: This objective and its target are consistent with the National Education Goal to increase school readiness and its objective to increase access to preschool programs for disadvantaged and disabled children.

8.4 Increase to at least 75 percent the proportion of the Nation's elementary and secondary schools that provide planned and sequential kindergarten–12th grade comprehensive school health education. (Baseline data unavailable)

8.5 Increase to at least 50 percent the proportion of postsecondary institutions with institution-wide health promotion programs for students, faculty, and staff. (Baseline: At least 20 percent of higher education institutions offered health promotion activities for students in 1989–90)

8.6 Increase to at least 85 percent the proportion of workplaces with 50 or more employees that offer health promotion activities for their employees, preferably as part of a comprehensive employee health promotion program. (Baseline: 65 percent of worksites with 50 or more employees offered at least one health promotion activity in 1985; 63 percent of medium and large companies had a wellness program in 1987)

8.7 Increase to at least 20 percent the proportion of hourly workers who participate regularly in employer-sponsored health promotion activities. (Baseline data unavailable)

8.8 Increase to at least 90 percent the proportion of people aged 65 and older who had the opportunity to participate during the preceding year in at least one organized health promotion program through a senior center, lifecare facility, or other community-based setting that serves older adults. (Baseline data unavailable)

8.9 Increase to at least 75 percent the proportion of people aged 10 and older who have discussed issues related to nutrition, physical activity, sexual behavior, tobacco, alcohol, other drugs, or safety with family members on at least one occasion during the preceding month. (Baseline: 54 percent of 9th–12th graders engaging in family discussion of HIV/AIDS)

8.10 Establish community health promotion programs that separately or together address at least three of the HEALTHY PEOPLE 2000 priorities and reach at least 40 percent of each State's population. (Baseline data unavailable)

8.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. (Baseline data unavailable)

Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.

8.12 Increase to at least 90 percent the proportion of hospitals, health maintenance organizations, and large group practices that provide patient education programs, and to at least 90 percent the proportion of community hospitals that offer community health promotion programs addressing the priority health needs of their communities. (Baseline: 68 percent of registered hospitals provided patient education services in 1987; 60 percent of community hospitals offered community health promotion programs in 1989)

8.13 Increase to at least 75 percent the proportion of local television network affiliates in the top 20 television markets that have become partners with one or more community organizations around one of the health problems addressed by the HEALTHY PEOPLE 2000 objectives. (Baseline data unavailable)

8.14 Increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health. (Baseline: percent of local health departments reporting health assessment, policy development, and health assurance activities in 1990)

Note: The core functions of public health have been defined as assessment, policy development, and assurance. Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.

Unintentional Injuries

Health Status Objectives

9.1 Reduce deaths caused by unintentional injuries to no more than 29.3 per 100,000 people. (Age-adjusted baseline: 34.7 per 100,000 in 1987)

Special Population Targets

	<i>Deaths Caused By Unintentional Injuries (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
9.1a	American Indians/Alaska Natives	66.0	53.0
9.1b	Black males	64.9	51.9
9.1c	White males	53.6	42.9
		<i>1990 Baseline</i>	<i>2000 Target</i>
9.1d	Mexican-American males	53.3	43.0

9.2 Reduce nonfatal unintentional injuries so that hospitalizations for this condition are no more than 754 per 100,000 people. (Baseline: 887 per 100,000 in 1988)

Special Population Target

	<i>Nonfatal Injuries (per 100,000)</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
9.2a	Black males	1,007	856

9.3 Reduce deaths caused by motor vehicle crashes to no more than 1.5 per 100 million vehicle miles traveled (VMT) and 14.2 per 100,000 people. (Baseline: 2.4 per 100 million vehicle miles traveled and 19.2 per 100,000 people in 1987)

Special Population Targets

	<i>Deaths Caused By Motor Vehicle Crashes (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
9.3a	Children aged 14 and younger	6.2	4.4
9.3b	Youth aged 15–24	36.9	26.8
9.3c	People aged 70 and older	22.6	20.0
9.3d	American Indians/Alaska Natives	37.7	32.0
		<i>1990 Baseline</i>	<i>2000 Target</i>
9.3g	Mexican Americans	20.9	18.0

Type-Specific Targets

	<i>Deaths Caused By Motor Vehicle Crashes</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
9.3e	Motorcyclists	40.9/100 million VMT	25.6/100 million VMT
		1.7/100,000	0.9/100,000
9.3f	Pedestrians	2.8/100,000	2.0/100,000

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9.4 Reduce deaths from falls and fall-related injuries to no more than 2.3 per 100,000 people. (Age-adjusted baseline: 2.7 per 100,000 in 1987)

Special Population Targets

	<i>Deaths From Falls and Fall-Related Injuries (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
9.4a	People aged 65–84	18.1	14.4
9.4b	People aged 85 and older	133.0	105.0
9.4c	Black men aged 30–69	8.1	5.6
		<i>1990 Baseline</i>	<i>2000 Target</i>
9.4d	American Indians/Alaska Natives	3.2	2.8

9.5 Reduce drowning deaths to no more than 1.3 per 100,000 people. (Age-adjusted baseline: 2.1 per 100,000 in 1987)

Special Population Targets

	<i>Drowning Deaths (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
9.5a	Children aged 4 and younger	4.2	2.3
9.5b	Men aged 15–34	4.5	2.5
9.5c	Black males	6.6	3.6
		<i>1990 Baseline</i>	<i>2000 Target</i>
9.5d	American Indians/Alaska Natives	4.3	2.0

9.6 Reduce residential fire deaths to no more than 1.2 per 100,000 people. (Age-adjusted baseline: 1.5 per 100,000 in 1987)

Special Population Targets

	<i>Residential Fire Deaths (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
9.6a	Children aged 4 and younger	4.4	3.3
9.6b	People aged 65 and older	4.4	3.3
9.6c	Black males	5.7	4.3
9.6d	Black females	3.4	2.6
		<i>1990 Baseline</i>	<i>2000 Target</i>
9.6f	American Indians/Alaska Natives	2.1	1.4
9.6g	Puerto Ricans	2.4	2.0

Type-Specific Target

		<i>1983 Baseline</i>	<i>2000 Target</i>
9.6e	Residential fire deaths caused by smoking	26%	8%

Appendix A: 1995 Summary List of Objectives

9.7 Reduce hip fractures among people aged 65 and older so that hospitalizations for this condition are no more than 607 per 100,000. (Baseline: 714 per 100,000 in 1988)

Special Population Target

	<i>Hip Fractures (per 100,000)</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
9.7a White women aged 85 and older		2,721	2,177

9.8 Reduce nonfatal poisoning to no more than 88 emergency department treatments per 100,000 people. (Baseline: 108 per 100,000 in 1986)

Special Population Target

	<i>Nonfatal Poisoning (per 100,000)</i>	<i>1986 Baseline</i>	<i>2000 Target</i>
9.8a Among children aged 4 and younger		648	520

9.9 Reduce nonfatal head injuries so that hospitalizations for this condition are no more than 106 per 100,000 people. (Baseline: 118 per 100,000 in 1988)

9.10 Reduce nonfatal spinal cord injuries so that hospitalizations for this condition are no more than 5 per 100,000 people. (Baseline: 5.3 per 100,000 in 1988)

Special Population Target

	<i>Nonfatal Spinal Cord Injuries (per 100,000)</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
9.10a Males		9.6	7.1

Risk Reduction Objectives

9.11 Reduce by 20 percent the incidence of secondary conditions (i.e., pressure sores) associated with traumatic spinal cord injuries. (Baseline data unavailable)

Note: Secondary conditions are defined as conditions causally related to a disabling condition (i.e., occurring as a result of the primary disabling condition) and can be either a pathology, an impairment, a functional limitation, or a disability).

9.12 Increase use of safety belts and child safety seats to at least 85 percent of motor vehicle occupants. (Baseline: 42 percent in 1988)

Special Population Target

	<i>1988 Baseline</i>	<i>2000 Target</i>
9.12a Use of Child Restraint Systems Among Children Aged 4 and Younger Involved in Potentially Fatal Crashes	48%	70%

9.13 Increase use of helmets to at least 80 percent of motorcyclists and at least 50 percent of bicyclists. (Baseline: 60 percent of motorcyclists in 1988 and an estimated 8 percent of bicyclists in 1984)

Services and Protection Objectives

- 9.14 Extend to 50 States laws requiring safety belt and motorcycle helmet use for all ages. (Baseline: 33 States and the District of Columbia in 1989 for automobiles; 22 States, the District of Columbia, and Puerto Rico for motorcycles)
- 9.15 Enact in 50 States laws requiring that new handguns be designed to minimize the likelihood of discharge by children. (Baseline: 0 States in 1989)
- 9.16 Extend to 2,000 local jurisdictions the number whose codes address the installation of fire suppression sprinkler systems in those residences at highest risk for fires. (Baseline: 700 jurisdictions in 1989)
- 9.17 Increase the presence of functional smoke detectors to at least one on each habitable floor of all inhabited residential dwellings. (Baseline: 81 percent of residential dwellings in 1989)
- 9.18 Provide academic instruction on injury prevention and control, preferably as part of comprehensive school health education, in at least 50 percent of public school systems (grades K–12). (Baseline data unavailable)
- 9.19* Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury. (Baseline: National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988)
- 9.20 Increase to at least 50 the number of States that have design standards for markings, signing, and other characteristics of the roadway environment to improve the visual stimuli and protect the safety of older drivers and pedestrians. (Baseline data unavailable)
- 9.21 Increase to at least 50 percent the proportion of primary care providers who routinely provide age-appropriate counseling on safety precautions to prevent unintentional injury. (Baseline: percentage of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians providing this service to 81–100 percent of patients in 1992)
- 9.22 Extend to 20 States the capability to link emergency medical services, trauma systems, and hospital data. (Baseline: 7 States in 1993)

1995 Additions

Health Status Objective

9.23* Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 5.5 per 100,000 people. (Baseline: 9.8 per 100,000 in 1987)

Services and Protection Objectives

9.24 Extend to 50 States laws requiring helmets for bicycle riders (Baseline: 9 States in 1994)

Source: National SAFE KIDS Campaign

Commentary:

Bicycle crashes result in 900 fatalities, 20,000 hospital admissions, and 580,000 emergency department visits each year. Children under age 16 represent about 42 percent of fatalities and 70 percent of nonfatal injuries. The societal costs of bicycle-related injuries and deaths is estimated to be about \$8 billion per year.

Head injury is involved in about 62 percent of bicycle-related deaths. Approximately one-third of all bicycle-related emergency department visits involve head injuries, as do two-thirds of all bicycle-related hospital admissions. Head injury is responsible for about 44 percent of all injury deaths in the United States, and approximately 7 percent of brain injuries are bicycle-related. Among survivors of nonfatal head injuries, the effects of brain injury can be profound, disabling, and long lasting.

Bicycle helmets are 85–88 percent effective in mitigating head and brain injury, making the use of helmets the single most effective countermeasure available to reduce head injuries and fatalities resulting from bicycle crashes. If a presumed helmet use rate of 10 percent in 1984–1988 had in fact been increased to 100 percent (i.e., universal helmet use) an average of 500 fatal and 151,400 nonfatal bicycle-related head injuries could have been prevented each year.

Helmet usage is currently about 15 percent for children under age 15 as reported in a 1991 study completed by the Consumer Product Safety Commission. Nine States have enacted statewide bicycle helmet laws, most of which cover only young riders. Although there have been few evaluations of these laws, those which have been conducted have shown significant improvements in helmet usage after enactment of the laws. Particularly when combined with a promotion campaign, legislation appears to be an effective approach to increase helmet use. While education is a necessary part of behavior change, it is rarely enough to convince the majority of people to change. Laws mandating helmet use supplement and reinforce the message of a promotional campaign and have the additional benefit of obviating a barrier to use by children—fear of peer derision.

9.25* Enact in 50 States laws requiring that firearms be properly stored to minimize access and the likelihood of discharge by minors. (Baseline: 0 States in 1993)

Source: *Center to Prevent Handgun Violence*

Commentary:

See commentary for objective 7.19 in *Violent and Abusive Behavior*.

9.26 Increase to 35 the number of States having a graduated driver licensing system for novice drivers and riders under the age of 18. (Baseline: 16 States in 1993)

Source: *National Highway Traffic Safety Administration*

A graduated driver licensing system is designed to ease young novice drivers into the driving environment through controlled exposure to progressively more difficult driving experience, or driver licensing stages, before full licensure. This system consists of three stages, learner's permit, intermediate license, and full license.

Teenage drivers are overrepresented in traffic crashes and twice as likely to be in a fatal crash as adult drivers. The problems contributing to their high crash rates include driving inexperience and lack of adequate driving skills, excessive driving during nighttime high-risk hours, excessive risk-taking, and poor driving judgment. Driving experience is required before young drivers achieve dependable skills, judgment, and performance. A graduated driver licensing system addresses the driving problems attributed to this group by increasing the amount of their supervised behind-the-wheel driving practice, increasing their exposure to progressively more difficult driving experiences under controlled conditions, and requiring them to earn full driving privileges by demonstrating crash- and conviction-free driving performance for a minimum period of time before advancing to the next stage of licensing.

The early stages of a graduated driver licensing system include provisions such as adult supervised driving, no alcohol use, nighttime driving restrictions, mandatory safety belt usage, license suspension for major violations, distinctive license from the regular driver's license, and mandatory helmet and eye protection usage by motorcycle riders. Evaluations done in three States with graduated licensing system components showed a 5–16 percent reduction in crashes involving 15- to 17-year-olds.

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Occupational Safety and Health

Health Status Objectives

10.1 Reduce deaths from work-related injuries to no more than 4 per 100,000 full-time workers. (Baseline: Average of 6 per 100,000 during 1983–87)

Special Population Targets

	<i>Work-Related Deaths (per 100,000)</i>	<i>1983–87 Average</i>	<i>2000 Target</i>
10.1a	Mine workers	30.3	21.0
10.1b	Construction workers	25.0	17.0
10.1c	Transportation workers	15.2	10.0
10.1d	Farm workers	14.0	9.5

10.2 Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity to no more than 6 cases per 100 full-time workers. (Baseline: 7.7 per 100 in 1983–87)

Special Population Targets

	<i>Work-Related Injuries (per 100)</i>	<i>1983–87 Average</i>	<i>2000 Target</i>
10.2a	Construction workers	14.9	10.0
10.2b	Nursing and personal care workers	12.7	9.0
10.2c	Farm workers	12.4	8.0
10.2d	Transportation workers	8.3	6.0
10.2e	Mine workers	8.3	6.0
		<i>1992 Baseline</i>	<i>2000 Target</i>
10.2f	Adolescent workers	5.8	3.8

10.3 Reduce cumulative trauma disorders to an incidence of no more than 60 cases per 100,000 full-time workers. (Baseline: 100 per 100,000 in 1987)

Special Population Targets

	<i>Cumulative Trauma Disorders (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
10.3a	Manufacturing industry workers	355	150
10.3b	Meat product workers	3,920	2,000

10.4 Reduce occupational skin disorders or diseases to an incidence of no more than 55 per 100,000 full-time workers. (Baseline: Average of 64 per 100,000 during 1983–87)

Risk Reduction Objectives

10.5* Reduce hepatitis B among occupationally exposed workers to an incidence of no more than 623 clinical cases. (Baseline: An estimated 3,090 clinical cases in 1987)

10.6 Increase to at least 95 percent the proportion of worksites with 50 or more employees that mandate employee use of occupant protection systems, such as seatbelts, during all work-related motor vehicle travel. (Baseline: 82.4 percent of worksites in 1992)

10.7 Reduce to no more than 15 percent the proportion of workers exposed to average daily noise levels that exceed 85 dBA. (Baseline: 16 percent in 1989)

10.8 Eliminate exposures which result in workers having blood lead concentrations greater than 25 μ /dL of whole blood. (Baseline: 4,804 workers with blood lead levels above 25 μ g/dL in 7 States in 1988)

10.9* Increase hepatitis B immunization levels to 90 percent among occupationally exposed workers. (Baseline: 37 percent in 1991)

Services and Protection Objectives

10.10 Implement occupational safety and health plans in 50 States for the identification, management, and prevention of leading work-related diseases and injuries within the State. (Baseline: 10 States in 1989)

10.11 Establish in 50 States exposure standards adequate to prevent the major occupational lung diseases to which their worker populations are exposed (byssinosis, asbestosis, coal workers' pneumoconiosis, and silicosis). (Baseline: Federal standards have been established for occupational exposure to airborne asbestos fibers, cotton dust, coal mine dust, and silica dust which apply to all 50 States.)

10.12 Increase to at least 70 percent the proportion of worksites with 50 or more employees that have implemented programs on worker health and safety. (Baseline: 63.8 percent in 1992)

10.13 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer back injury prevention and rehabilitation programs. (Baseline: 28.6 percent offered back care activities in 1985)

10.14 Establish in 50 States either public health or labor department programs that provide consultation and assistance to small businesses to implement safety and health programs for their employees. (Baseline: 26 States in 1991)

10.15 Increase to at least 75 percent the proportion of primary care providers who routinely elicit occupational health exposures as a part of patient history and provide relevant counseling. (Baseline: 6–14 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing this service to patients in 1992)

1995 Additions

Health Status Objectives

10.16 Reduce deaths from work-related homicides to no more than 0.5 per 100,000 full-time workers (Baseline: Average of 0.7 per 100,000 during 1980–1989)

Sources: National Traumatic Occupational Fatality (NTOF) Surveillance System, CDC in the numerator; U.S. Bureau of Census, Current Population Survey in the denominator. The U.S. Department of Labor, Bureau of Labor Statistics, Census of Fatal Occupational Injuries will also be used for tracking this objective.

Commentary:

Homicide is the third leading cause of fatal injury for all workers and the leading cause of fatal injury for women. Ongoing surveillance of occupational injury deaths in the United States, using the NTOF System, found that more than 7,600 workers lost their lives at work during the 1980s as a result of homicide. This translates into an average of 15 workers murdered at work each week during this decade. For the period 1980–1989, 12 percent of all injury deaths on the job were homicides. Among women, 41 percent of occupational injury deaths resulted from assaults. No current OSHA regulations apply specifically to occupational homicide.

Over 50 percent of work-related homicides occurred in two industry sectors, retail trades and services. NTOF data indicated that workers at greatest risk of work-related homicide were employees in the taxi industry (27 homicides per 100,000 workers), law enforcement officers (9 per 100,000), security guards (4 per 100,000) and employees of retail trades such as liquor stores (8 per 100,000), gasoline stations (6 per 100,000), grocery stores (3 per 100,000), and restaurants and bars (2 per 100,000). Employers in these high-risk establishments and occupations need to be aware of the risk for homicide and take steps to ensure a safe workplace. Although it was not possible to enumerate the number of work-related homicides in NTOF which occurred in convenience stores, an industry-funded study indicated a homicide rate of 20 per 100,000 for convenience store employees.

Seventy-five percent of work-related homicides were committed with firearms. Data from the Bureau of Labor Statistics' Census of Fatal Occupational Injuries in 1992 confirmed that the overwhelming majority of work-related homicides, 82 percent, were associated with robbery or miscellaneous crimes.

10.17 Reduce the overall age-adjusted mortality rate for four major preventable occupational lung diseases (byssinosis, asbestosis, coal workers' pneumoconiosis, and silicosis) to 7.7 per 100,000. (Baseline: 9.6 per 100,000 in 1990)

Source: CDC/NCHS, National Vital Statistics Systems

Note: Secondary conditions are defined as conditions causally related to a disabling condition (i.e., occurs as a result of the primary disabling condition) and that can be either a pathology, an impairment, a functional limitation or a disability).

Commentary:

This new objective complements the services and protection objective 10.11. NIOSH has tracked these rates since 1970 and published the Work-Related Lung Disease Surveillance Report in 1991 and its supplement in 1992. Using 1990 as a base year (with an overall age-adjusted mortality rate with asbestosis, byssinosis, coal workers' pneumoconiosis, or silicosis of 9.6), a 20 percent reduction per decade would suggest an overall age-adjusted mortality rate of no more than 7.7 per 100,000 by the year 2000. This reduction per decade targeting will enable continuation of setting lower targets at the beginning of each subsequent decade. The mortality rate will be targeted to decline until these diseases are at extremely low levels, while reflecting the realistic expectation of not achieving a total elimination of diseases with such long latency in the near term.

Exposure standards alone do not guarantee success in preventing disease. NIOSH hazard surveillance activities demonstrate that standards are frequently violated with worker exposures far exceeding those considered permissible by regulatory agencies. In addition, many standards are outdated and may not be adequate to prevent disease.

In 1992 NIOSH published two Alerts requesting assistance in preventing morbidity and mortality with silicosis in sandblasting and rock drilling operations. The publications describe results from health hazard evaluations at worksites where current OSHA permissible exposure limit (PEL) for respirable crystalline silica were grossly violated, resulting in death of workers as young as 34. At one worksite, a sandblaster developed acute silicosis at the age of 23. The current PEL is 100 micrograms per cubic meter (100 $\mu\text{g}/\text{m}^3$) as an 8-hour time-weighted average (TWA), with a NIOSH recommended exposure level (REL) of 50 $\mu\text{g}/\text{m}^3$. At one location, NIOSH recorded exposures to respirable crystalline silica as high as 3,400 $\mu\text{g}/\text{m}^3$ as a TWA. Therefore, establishment of standards has not resulted in the elimination of conditions leading to disease. Rather, it is the application of adequate control measures in workplaces that protects workers.

Services and Protection Objectives

10.18* Increase to 100 percent the proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace. (Baseline: 27 percent of worksites with 50 or more employees in 1985; 54 percent of medium and large companies in 1987)

10.19* Enact in 50 States and the District of Columbia comprehensive laws on clean indoor air that prohibit smoking or limit it to separately ventilated areas in the workplace and enclosed public places (Baseline: 4 States regulated private workplaces; 8 States regulated public workplaces including those that banned smoking through Executive Orders; 2 States regulated restaurants; 14 States and the District of Columbia regulated public transportation; 9 States regulated hospitals; 21 States regulated day care centers, and 6 States regulated grocery stores with comprehensive laws as of January 1995)

10.20* Reduce to 0 the number of States that have clean indoor air laws preempting stronger clean indoor air laws on the local level. (Baseline: 17 States had preemptive clean indoor air laws as of January 1995)

Environmental Health

Health Status Objectives

11.1 Reduce asthma morbidity, as measured by a reduction in asthma hospitalizations to no more than 160 per 100,000 people. (Baseline: 188 per 100,000 in 1987)

Special Population Targets

	Asthma Hospitalizations (per 100,000)	1987 Baseline	2000 Target
11.1a Blacks and other nonwhites		334	265
11.1b Children		284 [†]	225
		1988 Baseline	2000 Target
11.1c Women		229	183

[†]Children aged 14 and younger

11.2* Reduce the prevalence of serious mental retardation among school-aged children to no more than 2 per 1,000 children. (Baseline: 2.7 per 1,000 children aged 10 in 1985–88)

Note: Serious mental retardation is defined as an Intelligence Quotient (I.Q.) less than 50. This includes individuals defined by the American Association of Mental Retardation as profoundly retarded (I.Q. of 20 or less), severely retarded (I.Q. of 21–35), and moderately retarded (I.Q. of 36–50).

11.3 Reduce outbreaks of waterborne disease from infectious agents and chemical poisoning to no more than 11 per year. (Baseline: 16 outbreaks in 1988)

Type-Specific Target

	Average Annual Number of Waterborne Disease Outbreaks	1988 Baseline	2000 Target
11.3a People served by community water systems		4	2

Note: Includes only outbreaks from water intended for drinking. Community water systems are public or investor-owned water systems that serve large or small communities, subdivisions, or trailer parks with at least 15 service connections or 25 year-round residents.

11.4 Reduce the prevalence of blood lead levels exceeding 15 µg/dL and 25 µg/dL among children aged 6 months – 5 years to no more than 300,000 and zero, respectively. (Baseline: An estimated 3 million children had levels exceeding 15 µg/dL, and 234,000 had levels exceeding 25 µg/dL, in 1984)

Special Population Targets

	Prevalence of Blood Lead Levels	1984 Baseline	2000 Target
11.4a Inner-city low-income black children (annual family income <\$6,000 in 1984 dollars)			
	exceeding 15 mg/dL	234,900	75,000
	exceeding 25 µg/dL	36,700	0

Risk Reduction Objectives

11.5 Reduce human exposure to criteria air pollutants, as measured by an increase to at least 85 percent in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months. (Baseline: 49.7 percent in 1988)

<i>Proportion Living in Counties That Have Not Exceeded Criteria Air Pollutant Standards</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
Ozone	53.6%	—
Carbon monoxide	87.8%	—
Nitrogen dioxide	96.6%	—
Sulfur dioxide	99.3%	—
Particulates	89.4%	—
Lead	99.3%	—
Total (any of above pollutants)	49.7%	85%

Note: An individual living in a county that exceeds an air quality standard may not actually be exposed to unhealthy air. Of all criteria air pollutants, ozone is the most likely to have fairly uniform concentrations throughout an area. Exposure is to criteria air pollutants in ambient air. Due to weather fluctuations, multiyear averages may be the most appropriate way to monitor progress toward this objective.

11.6 Increase to at least 40 percent the proportion of homes in which homeowners/occupants have tested for radon concentrations and that have either been found to pose minimal risk or have been modified to reduce risk to health. (Baseline: Less than 5 percent of homes had been tested in 1989)

Special Population Targets

	<i>Testing and Modification As Necessary</i>	<i>Baseline</i>	<i>2000 Target</i>
11.6a	Homes with smokers and former smokers	—	50%
11.6b	Homes with children	—	50%

11.7 Reduce human exposure to toxic agents by decreasing the release of hazardous substances from industrial facilities: 65 percent decrease in the substances on the Department of Health and Human Services list of carcinogens, and a 50 percent reduction in the substances on the Agency for Toxic Substances and Disease Registry (ATSDR) priority list of the most toxic chemicals. (Baseline: 0.36 billion pounds on the Department of Health and Human Services list of carcinogens, and 1.93 billion pounds on the ATSDR list of the most toxic chemicals in 1988)

11.8 Reduce human exposure to solid waste-related water, air, and soil contamination, as measured by a reduction in average pounds of municipal solid waste produced per person each day to no more than 4.3 pounds before recovery and 3.2 pounds after recovery. (Baseline: 4.0 pounds per person each day in 1988)

*Exposure to Solid Waste-
Contamination (Average Pounds*

<i>Per Person Each Day)</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
Total population	4.0	4.3
After recovery (recycling & composting)	3.5	3.2

Source: Characterization of Municipal Solid Waste in the United States, EPA.

11.9 Increase to at least 85 percent the proportion of people who receive a supply of drinking water that meets the safe drinking water standards established by the Environmental Protection Agency. (Baseline: 74 percent of 58,099 community water systems serving approximately 80 percent of the population in 1988)

Note: Compliance with the Safe Drinking Water Act includes monitoring and reporting as well as providing water that meets the Maximum Contaminant Level (MCL) standards set by the Environmental Protection Agency which define acceptable levels of contaminants. See Objective 11.3 for definition of community water systems.

11.10 Reduce potential risks to human health from surface water, as measured by an increase in the proportion of assessed rivers, lakes, and estuaries that support beneficial uses, such as consumable fish and recreational activities.

Note: Designated beneficial uses, such as aquatic life support, contact recreation (swimming), and water supply, are designated by each State and approved by the Environmental Protection Agency. Support of beneficial use is a proxy measure of risk to human health, as many pollutants causing impaired water uses do not have human health effects (e.g., siltation, impaired fish habitat).

<i>Water Supporting Beneficial Use</i>	<i>1992 Baseline</i>	<i>2000 Target</i>
<i>Rivers supporting:</i>		
Consumable fish	89%	94%
Recreational activities	71%	85%
<i>Lakes supporting:</i>		
Consumable fish	64%	82%
Recreational activities	77%	88%
<i>Estuaries supporting:</i>		
Consumable fish	94%	97%
Recreational activities	83%	91%

Source: National Water Quality Inventory, 1992 Preliminary Report, EPA.

Services and Protection Objectives

11.11 Perform testing for lead-based paint in at least 50 percent of homes built before 1950. (Baseline: 5 percent in 1991)

11.12 Expand to at least 35 the number of States in which at least 75 percent of local jurisdictions have adopted construction standards and techniques that minimize elevated indoor radon levels in those new building areas locally determined to have elevated radon levels. (Baseline: 1 State in 1989)

Note: Since construction codes are frequently adopted by local jurisdictions rather than States, progress toward this objective also may be tracked using the proportion of cities and counties that have adopted such construction standards.

11.13 Increase to at least 30 the number of States requiring that prospective buyers be informed of the presence of lead-based paint and radon concentrations in all buildings offered for sale. (Baseline: 2 States required disclosure of lead-based paint in 1989; 1 State required disclosure of radon concentrations in 1989; 2 additional States required disclosure that radon has been found in the State and that testing is desirable in 1989)

11.14 Eliminate significant health risks from National Priority List hazardous waste sites, as measured by performance of clean-up at these sites sufficient to eliminate immediate and significant health threats as specified in health assessments completed at all sites. (Baseline: 1,082 sites were on the list in March of 1990; of these, health assessments have been conducted for approximately 1,000)

Note: The Comprehensive Environmental Response, Compensation, and Liability Act of 1980 required the Environmental Protection Agency to develop criteria for determining priorities among hazardous waste sites and to develop and maintain a list of these priority sites. The resulting list is called the National Priorities List (NPL).

11.15 Establish curbside recycling programs that serve at least 50 percent of the U.S. population and continue to increase household hazardous waste collection programs.

<i>Recyclable Materials and Household Hazardous Waste Programs</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
Percentage of population served by curbside recycling programs	26%	50%
<i>Permanent and temporary household hazardous waste collection events</i>		
Permanent	96	215
Temporary	706	1,314
Total	802	1,529

Sources: Recycling data from Biocycle Journal of Waste Recycling. Household hazardous waste collection data from the Waste Watch Center.

11.16 Establish and monitor in at least 35 States plans to define and track sentinel environmental diseases. (Baseline: 0 States in 1990)

Note: Sentinel environmental diseases include lead poisoning, other heavy metal poisoning (e.g., cadmium, arsenic, and mercury), pesticide poisoning, carbon monoxide poisoning, heatstroke, hypothermia, acute chemical poisoning, methemoglobinemia, and respiratory diseases triggered by environmental factors (e.g., asthma).

1995 Addition

Risk Reduction Objective

11.17* Reduce to no more than 20 percent the proportion of children aged 6 and younger who are regularly exposed to tobacco smoke at home. (Baseline: More than 39 percent in 1986, as 39 percent of households with one or more children aged 6 or younger had a cigarette smoker in the household)

Note: Regular exposure to tobacco smoke at home is defined as the occurrence of tobacco smoking anywhere in the home on more than 3 days each week.

Food and Drug Safety

Health Status Objectives

12.1 Reduce infections caused by key foodborne pathogens to incidences of no more than:

<i>Disease (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
<i>Salmonella</i> species	18.0	16.0
<i>Campylobacter jejuni</i>	50.0	25.0
<i>Escherichia coli</i> O157:H7	8.0	4.0
<i>Listeria monocytogenes</i>	0.7	0.5

12.2 Reduce outbreaks of infections due to *Salmonella enteritidis* to fewer than 25 outbreaks yearly. (Baseline: 77 outbreaks in 1989)

Risk Reduction Objective

12.3 Increase to at least 75 percent the proportion of households in which principal food preparers routinely refrain from leaving perishable food out of the refrigerator for over 2 hours and wash cutting boards and utensils with soap after contact with raw meat and poultry. (Baseline: For refrigeration of perishable foods, 70 percent; for washing cutting boards with soap, 66 percent; and for washing utensils with soap, 55 percent, in 1988)

Services and Protection Objectives

12.4 Extend to at least 70 percent the proportion of States and territories that have implemented *Food Code 1993* for institutional food operations and to at least 70 percent the proportion that have adopted the new uniform food protection code that sets recommended standards for regulation of all food operations. (Baseline: 0 percent in 1994)

12.5 Increase to at least 75 percent the proportion of pharmacies and other dispensers of prescription medications that use linked systems to provide alerts to potential adverse drug reactions among medications dispensed by different sources to individual patients. (Baseline: 95 percent of pharmacies utilized computer systems in 1993)

12.6 Increase to at least 75 percent the proportion of primary care providers and other dispensers of medicine who routinely review with their patients aged 65 and older all prescribed and over-the-counter medicines taken by their patients each time a new medication is prescribed or dispensed. (Baseline: percentage of clinicians who routinely provide service—nurse practitioners, 55 percent; obstetricians/ gynecologists, 64 percent; internists, 84 percent; and family physicians, 63 percent of patients in 1992)

1995 Additions

Services and Protection Objectives

12.7 Increase to at least 75 percent the proportion of the total number of adverse event reports voluntarily sent directly to FDA that are regarded as serious. (Baseline: 69 percent based on first 7 months in 1993)

Source: FDA, MedWatch

Commentary:

On June 3, 1993, FDA announced MedWatch, the new FDA Medical Products Reporting Program. MedWatch is an outreach program to the health care professional community that will enable FDA to discover more quickly the adverse reactions and interactions that Drug Utilization Review, through the use of linked data bases, seeks to avoid. The expanded definition of serious being promoted by MedWatch includes "life-threatening" and "requires intervention to prevent permanent impairment or damage" as well as death, hospitalization, disability and congenital anomaly. Sixty-nine percent of adverse drug event reports submitted to the MedWatch program during its first 7 months have been serious.

MedWatch is an educational initiative for health professionals about the importance of reporting adverse events with medical products and to facilitate reporting. Increasing the percentage of serious adverse event reports results in a greater likelihood of receiving information that would be a significant contribution for safety data analysis and of decreasing the amount of less significant information that would congest the system. Increasing the percentage of serious reports increases the efficiency of the system and is also a measure of the success of educational messages sent to health professionals.

12.8 Increase to at least 75 percent the proportion of people who receive useful information verbally and in writing for new prescriptions from prescribers or dispensers. (Baseline: for written information, 14 percent from prescribers and 25 percent from dispensers in 1992)

Source: FDA national random telephone survey of adults, 1992

Commentary:

This objective measures what information patients state they receive, rather than relying on reports of health care providers. The research literature in patient education consistently shows that it is not what health professionals say or do, it is what patients know and understand that makes a difference in patient behavior and their health status. The research also indicates that patients make use of many different sources of health information besides health professionals, depending on their learning styles and motivations, and that multiple channels of exposure to information prove most effective in educating patients.

In order to obtain baseline data, FDA conducted a national random telephone survey of 1,023 adult respondents who had received a prescription within the previous 4 weeks. In the survey, FDA asked whether various types of information were received from a physician, such as how much of the medication to take, how often to take it, precautions to be aware of, and information associated with side effects. These data show that 14 percent of the respondents reported receiving written medication information from their physician. Baseline data for counseling on various drug information topics ranged from 29 percent to 55 percent for physicians and between 13 percent to 32 percent for pharmacists.

Prescribers are people who are authorized to prescribe, including physicians, nurse practitioners, and physician assistants depending on State law. Dispensers are authorized to dispense prescription medications and include physicians and pharmacists.

Oral Health

Health Status Objectives

13.1 Reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 35 percent among children aged 6–8 and no more than 60 percent among adolescents aged 15. (Baseline: 54 percent of children aged 6–8 in 1986–87; 78 percent of adolescents aged 15 in 1986–87)

Special Population Targets

	<i>Dental Caries Prevalence</i>	<i>1986–87 Baseline</i>	<i>2000 Target</i>
13.1a	Children aged 6–8 whose parents have less than high school education	70%	45%
13.1b	American Indian/Alaska Native children aged 6–8	92% [†] 52% [‡]	45%
13.1c	Black children aged 6–8	56%	40%
13.1d	American Indian/Alaska Native adolescents aged 15	93% [‡]	70%

[†]In primary teeth in 1983–84 [‡]In permanent teeth in 1983–84

13.2 Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 20 percent among children aged 6–8 and no more than 15 percent among adolescents aged 15. (Baseline: 28 percent of children aged 6–8 in 1986; 24 percent of adolescents aged 15 in 1986–87)

Special Population Targets

	<i>Untreated Dental Caries Among:</i>	<i>1986–87 Baseline</i>	<i>2000 Target</i>
13.2a	Children aged 6–8 whose parents have less than high school education	43%	30%
13.2b	American Indian/Alaska Native children aged 6–8	64% [†]	35%
13.2c	Black children aged 6–8	36%	25%
13.2d	Hispanic children aged 6–8	36% [‡]	25%
13.2e	<i>Among:</i> Adolescents aged 15 whose parents have less than a high school education	41%	25%
13.2f	American Indian/Alaska Native adolescents aged 15	84% [†]	40%
13.2g	Black adolescents aged 15	38%	20%
13.2h	Hispanic adolescents aged 15	31–47% [‡]	25%

[†]1983–84 baseline [‡]1982–84 baseline

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13.3 Increase to at least 45 percent the proportion of people aged 35–44 who have never lost a permanent tooth due to dental caries or periodontal diseases. (Baseline: 31 percent of employed adults had never lost a permanent tooth for any reason in 1985–86)

Note: Never lost a permanent tooth is having 28 natural teeth exclusive of third molars.

13.4 Reduce to no more than 20 percent the proportion of people aged 65 and older who have lost all of their natural teeth. (Baseline: 36 percent in 1986)

Special Population Targets

	<i>Complete Tooth Loss Prevalence</i>	<i>1986 Baseline</i>	<i>2000 Target</i>
13.4a	Low-income people (annual family income <\$15,000)	46%	25%
13.4b	American Indians/Alaska Natives	42%	20%

13.5 Reduce the prevalence of gingivitis among people aged 35–44 to no more than 30 percent. (Baseline: 41 percent in 1985–86)

Special Population Targets

	<i>Gingivitis Prevalence</i>	<i>1985 Baseline</i>	<i>2000 Target</i>
13.5a	Low-income people (annual family income <\$12,500)	50%	35%
13.5b	American Indians/Alaska Natives	95% [†]	50%
13.5c	Hispanics	50%	
	Mexican Americans	74% [‡]	
	Cubans	79% [‡]	
	Puerto Ricans	82% [‡]	

[†]1983–84 baseline [‡]1982–84 baseline

13.6 Reduce destructive periodontal diseases to a prevalence of no more than 15 percent among people aged 35–44. (Baseline: 25 percent in 1985–86)

Note: Destructive periodontal disease is one or more sites with 4 millimeters or greater loss of tooth attachment.

13.7* Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline: 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

Special Population Targets

	<i>Oral Cancer Deaths (per 100,000)</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
13.7a	Black males aged 45–74	29.4	26.0
13.7b	Black females aged 45–74	6.9	6.9

Risk Reduction Objectives

13.8 Increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth. (Baseline: 11 percent of children aged 8 and 8 percent of adolescents aged 14 in 1986–87)

Note: Progress toward this objective will be monitored based on prevalence of sealants in children at age 8 and at age 14, when the majority of first and second molars, respectively, are erupted.

Special Population Targets

	<i>Dental Sealants</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
13.8a	Blacks aged 8	5%	50%
13.8b	Blacks aged 14	4%	50%
13.8c	Hispanics aged 8	8%	50%
13.8d	Hispanics aged 14	4%	50%

13.9 Increase to at least 75 percent the proportion of people served by community water systems providing optimal levels of fluoride. (Baseline: 61 percent in 1989)

Note: Optimal levels of fluoride are determined by the mean maximum daily air temperature over a 5-year period and range between 0.7 and 1.2 parts of fluoride per one million parts of water (ppm).

13.10 Increase use of professionally or self-administered topical or systemic (dietary) fluorides to at least 85 percent of people not receiving optimally fluoridated public water. (Baseline: An estimated 50 percent in 1989)

13.11* Increase to at least 75 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay. (Baseline: 55 percent of parents and caregivers of children 6–23 months of age in 1991)

Special Population Targets

	<i>Appropriate Feeding Practices</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
13.11a	Parents and caregivers with less than high school education	36%	65%
13.11b	American Indian/Alaska Native parents and caregivers	74% [†]	65%
13.11c	Black parents and caregivers	48%	65%
13.11d	Hispanic parents and caregivers	39%	65%

[†] 1985–89 data in four IHS Service Areas in a pilot study

Note: Percentage of parents and caregivers of children 6–23 months of age. Appropriate feeding practices are that the child no longer uses a bottle during the past 2 weeks or if the child still uses a bottle that no bottle was given at bedtime, excluding bottles with plain water, during the past 2 weeks.

Services and Protection Objectives

13.12 Increase to at least 90 percent the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and followup for necessary diagnostic, preventive, and treatment services. (Baseline: 66 percent of children aged 5 visited a dentist during the previous year in 1986)

Special Population Targets

Percentage of Children Visiting a Dentist	1991 Baseline	2000 Target
13.12a Blacks aged 5	51%	90%
13.12b Hispanics aged 5	51%	90%

Note: School programs include Head Start, prekindergarten, kindergarten, and first grade.

13.13 Extend to all long-term institutional facilities the requirement that oral examinations and services be provided no later than 90 days after entry into these facilities. (Baseline: Nursing facilities receiving Medicaid or Medicare reimbursement will be required to provide for oral examinations within 90 days of patient entry beginning in 1990; baseline data unavailable for other institutions)

Note: Long-term institutional facilities include nursing homes, prisons, juvenile homes, and detention facilities.

13.14 Increase to at least 70 percent the proportion of people aged 35 and older using the oral health care system during each year. (Baseline: 54 percent in 1986)

Special Population Targets

Proportion Using Oral Health Care System During Each Year	1986 Baseline	2000 Target
13.14a Edentulous people	11%	50%
13.14b People aged 65 and older	42%	60%
	1991 Baseline	2000 Target
13.14c Blacks aged 35 and older	43%	60%
13.14d Mexican Americans aged 35 and older	38%	60%
13.14e Puerto Ricans aged 35 and older	51%	60%

13.15 Increase to at least 40 the number of States that have an effective system for recording and referring infants with cleft lips and/or palates to craniofacial anomaly teams. (Baseline: In 1988, approximately 25 States had a central recording mechanism for cleft lip and/or palate, and approximately 25 States had an organized referral system to craniofacial anomaly teams)

Appendix A: 1995 Summary List of Objectives

13.15	<i>Identification and Referral of Infants With Clefts</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
	States with system to identify clefts	25	40
	States with system to refer for care*	20	40
	States with system to follow-up	27 [†]	40
	States with system to identify and refer	11	40

[†]1993 Illinois Department of Health Survey

13.16* Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury. (Baseline: National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988)

1995 Addition

Risk Reduction Objective

13.17* Reduce smokeless tobacco use by males aged 12–24 to a prevalence of no more than 4 percent. (Baseline: 6.6 percent among males aged 12–17 in 1988; 8.9 percent among males aged 18–24 in 1987)

Special Population Target

	<i>Smokeless Tobacco Use</i>	<i>1986–87 Baseline</i>	<i>2000 Target</i>
13.17a	American Indian/Alaska Native youth	18–64%	10%

Note: For males aged 12–17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18–24, a smokeless tobacco user is someone who has used either snuff or chewing tobacco at least 20 times and who currently uses snuff or chewing tobacco.

Maternal and Infant Health

Health Status Objectives

14.1 Reduce the infant mortality rate to no more than 7 per 1,000 live births.
(Baseline: 10.1 per 1,000 live births in 1987)

Special Population Targets

	<i>Infant Mortality (per 1,000 live births)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
14.1a	Blacks	18.8	11.0
14.1b	American Indians/Alaska Natives	13.4 [†]	8.5
14.1c	Puerto Ricans	12.9 [†]	8.0

Type-Specific Targets

	<i>Neonatal and Postneonatal Mortality (per 1,000 live births)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
14.1d	Neonatal mortality	6.5	4.5
14.1e	Neonatal mortality among blacks	12.3	7.0
14.1f	Neonatal mortality among Puerto Ricans	8.6 [†]	5.2
14.1g	Postneonatal mortality	3.6	2.5
14.1h	Postneonatal mortality among blacks	6.4	4.0
14.1i	Postneonatal mortality among American Indians/Alaska Natives	7.0 [†]	4.0
14.1j	Postneonatal mortality among Puerto Ricans	4.3 [†]	2.8

[†]1984 baseline

Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.

14.2 Reduce the fetal death rate (20 or more weeks of gestation) to no more than 5 per 1,000 live births plus fetal deaths. (Baseline: 7.6 per 1,000 live births plus fetal deaths in 1987)

Special Population Target

	<i>Fetal Deaths</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
14.2a	Blacks	13.1 [‡]	7.5 [‡]

[‡] Per 1,000 live births plus fetal deaths

14.3 Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births. (Baseline: 6.6 per 100,000 in 1987)

Special Population Target

	<i>Maternal Mortality (Per 100,000 live births)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
14.3a	Blacks	14.9	5.0

Appendix A: 1995 Summary List of Objectives

Note: The objective uses the maternal mortality rate as defined by the National Center for Health Statistics. However, if other sources of maternal mortality data are used, a 50-percent reduction in maternal mortality is the intended target.

14.4 Reduce the incidence of fetal alcohol syndrome to no more than 0.12 per 1,000 live births. (Baseline: 0.22 per 1,000 live births in 1987)

Special Population Targets

	<i>Fetal Alcohol Syndrome (per 1,000 live births)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
14.4a	American Indians/Alaska Natives	4.0	2.0
14.4b	Blacks	0.8	0.4

Risk Reduction Objectives

14.5 Reduce low birthweight to an incidence of no more than 5 percent of live births and very low birthweight to no more than 1 percent of live births. (Baseline: 6.9 and 1.2 percent, respectively, in 1987)

Special Population Targets

	<i>Low Birthweight</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
14.5a	Blacks	13.0%	9%
	<i>Very Low Birthweight</i>		
14.5b	Blacks	2.8%	2%
	<i>Low Birthweight</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
14.5c	Puerto Ricans	9.0%	6%
	<i>Very Low Birthweight</i>		
14.5d	Puerto Ricans	1.6%	1%

Note: Low birthweight is weight at birth of less than 2,500 grams; very low birthweight is weight at birth of less than 1,500 grams.

14.6 Increase to at least 85 percent the proportion of mothers who achieve the minimum recommended weight gain during their pregnancies. (Baseline: 67 percent of married women in 1980)

Note: Recommended weight gain is pregnancy weight gain recommended in the 1990 National Academy of Science's report, Nutrition During Pregnancy.

14.7 Reduce severe complications of pregnancy to no more than 15 per 100 deliveries. (Baseline: 22 hospitalizations (prior to delivery) per 100 deliveries in 1987)

Special Population Target

	<i>Pregnancy Complications (per 100 deliveries)</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
14.7a	Blacks	28	16

Note: Severe complications of pregnancy will be measured using hospitalizations due to pregnancy-related complications.

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14.8 Reduce the cesarean delivery rate to no more than 15 per 100 deliveries.
(Baseline: 24.4 per 100 deliveries in 1987)

Type-Specific Targets

	<i>Cesarean Delivery (per 100 deliveries)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
14.8a	Primary (first time) cesarean delivery	17.4	12
14.8b	Repeat cesarean deliveries	91.2 [†]	65 [†]

[†]Among women who had a previous cesarean delivery

14.9* Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 54 percent during early postpartum and 21 percent who are still breastfeeding at 5 to 6 months in 1988)

Special Population Targets

	<i>Mothers Breastfeeding Their Babies: During Early Postpartum Period:</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
14.9a	Low-income mothers	32%	75%
14.9b	Black mothers	25%	75%
14.9c	Hispanic mothers	51%	75%
14.9d	American Indian/Alaska Native mothers	47%	75%
	<i>At Age 5–6 Months:</i>		
14.9e	Low-income mothers	9%	50%
14.9f	Black mothers	8%	50%
14.9g	Hispanic mothers	16%	50%
14.9h	American Indian/Alaska Native mothers	28%	50%

Note: The definition used for breastfeeding includes exclusive use of human milk or the use of human milk with a supplemental bottle of formula or cow's milk.

14.10 Increase abstinence from tobacco use by pregnant women to at least 90 percent and increase abstinence from alcohol, cocaine, and marijuana by pregnant women by at least 20 percent. (Baseline: 75 percent of pregnant women abstained from tobacco use in 1985)

	<i>1988 Baseline</i>	<i>2000 Target</i>
Tobacco	78% [†]	90%
Alcohol	79%	95%
Cocaine	99%	100%
Marijuana	98%	100%

[†]1987 data

Services and Protection Objectives

14.11 Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. (Baseline: 76 percent of live births in 1987)

Special Population Targets

	<i>Proportion of Pregnant Women Receiving Early Prenatal Care (Percent of live births)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
14.11a Black women		60.8%	90%
14.11b American Indian/Alaska Native women		57.6%	90%
14.11c Hispanic women		61.0%	90%

14.12* Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline: 18–65 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

14.13 Increase to at least 90 percent the proportion of women enrolled in prenatal care who are offered screening and counseling on prenatal detection of fetal abnormalities. (Baseline: 29 percent in 1988)

14.14 Increase to at least 90 percent the proportion of pregnant women and infants who receive risk-appropriate care. (Baseline data unavailable)

14.15 Increase to at least 95 percent the proportion of newborns screened by State-sponsored programs for genetic disorders and other disabling conditions and to 90 percent the proportion of newborns testing positive for disease who receive appropriate treatment. (Baseline: For sickle cell anemia, with 20 States reporting, approximately 33 percent of live births screened [57 percent of black infants]; for galactosemia, with 38 States reporting, approximately 70 percent of live births screened)

Note: As measured by the proportion of infants served by programs for sickle cell anemia and galactosemia. Screening programs should be appropriate for State demographic characteristics.

14.16 Increase to at least 90 percent the proportion of babies aged 18 months and younger who receive recommended primary care services at the appropriate intervals. (Baseline data unavailable)

1995 Addition

Health Status Objective

14.17 Reduce the incidence of spina bifida and other neural tube defects to 3 per 10,000 live births. (Baseline: 6 per 10,000 in 1990)

Source: Birth Defect Monitoring System, CDC.

Commentary:

Spina bifida and anencephaly are common and serious birth defects known as neural tube defects (NTDs). Anencephaly is invariably fatal, whereas about 80 percent of babies with spina bifida survive. Persons with spina bifida usually have lower body paralysis with bowel and bladder incontinence. There are about 4,000 NTD-affected pregnancies in the United States each year. Between 2,000 and 3,000 of these pregnancies result in term births, while the remainder are identified prenatally and terminated by induced abortion.

In 1991, a British-funded randomized clinical trial of women who had a previous pregnancy affected with spina bifida or other NTD showed that folic acid reduced the risk of having a subsequent affected pregnancy by about 70 percent.¹ In 1992, a second randomized clinical trial conducted in Hungary among women with no history of NTD also showed a statistically significant reduction in risk.² Three major case control studies in the United States have documented that the risk of NTD-affected pregnancy among women who consume 400 µg of folic acid daily in a vitamin supplement is less than half the risk among women who consume folate from only dietary sources (on average 200 µg per day).³⁻⁵ The results of these and other studies led to consensus among agencies of the U.S. Public Health Service (PHS) that folic acid prevents NTD. In September 1992, the PHS published a recommendation that all women capable of becoming pregnant should continue 400 µg folic acid per day for the purpose of reducing the risk of spina bifida and other neural tube defects.

The reason for recommending daily use of folic acid is that the crucial time to consume folic acid for the purpose of preventing NTD-affected pregnancies is from about 1 month before conception and throughout early pregnancy. Since it has been estimated that 50 percent of pregnancies in the United States are not planned,⁷ to maximize NTD prevention it is necessary to recommend that all women who are capable of becoming pregnant consume 400 µg of folic acid daily. Educational efforts are underway to increase the awareness of the folic acid NTD prevention among the general population. PHS is also considering the possibility of fortifying cereal grain products with folic acid.

Based on a synthesis of information from several studies including those which used multivitamins containing folic acid at a daily dose level of at least 0.4 mg, it was inferred that folic acid alone at levels of 0.4 mg per day will reduce the risk of NTDs. The protective effect found in the studies of lower-dose folic acid, measured

by the reduction in NTD incidence, ranged from none to substantial; a reasonable estimate of the expected reduction in the United States is 50 percent.⁶

A trend of decreasing birth prevalence of neural tube defects (spina bifida and anencephaly) has been observed over the past 25 years by the CDC Birth Defects surveillance program. It is possible that at least some of this decrease has been the result of increased regular use of supplements containing folic acid by women of childbearing age.⁸

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Heart Disease and Stroke

Health Status Objectives

15.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

Special Population Target

	Coronary Deaths (per 100,000)	1987 Baseline	2000 Target
15.1a Blacks		168	115

15.2* Reduce stroke deaths to no more than 20 per 100,000 people. (Age-adjusted baseline: 30.4 per 100,000 in 1987)

Special Population Target

	Stroke Deaths (per 100,000)	1987 Baseline	2000 Target
15.2a Blacks		52.5	27

15.3 Reverse the increase in end-stage renal disease (requiring maintenance dialysis or transplantation) to attain an incidence of no more than 13 per 100,000. (Baseline: 14.4 per 100,000 in 1987)

Special Population Target

	ESRD Incidence (per 100,000)	1987 Baseline	2000 Target
15.3a Blacks		34.0	30

Risk Reduction Objectives

15.4* Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control. (Baseline: 11 percent controlled among people aged 18–74 in 1976–80)

Special Population Target

	High Blood Pressure Control	1976–80 Baseline	2000 Target
15.4a Men with high blood pressure		6%	40%
15.4b Mexican Americans		14%	50%
15.4c Women 70 years and older		19%	50%

Note: People with high blood pressure have blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or take antihypertensive medication. Blood pressure control is defined as maintaining a blood pressure less than 140 mm Hg systolic and 90 mm Hg diastolic. Control of hypertension does not include nonpharmacologic treatment.

Appendix A: 1995 Summary List of Objectives

15.5 Increase to at least 90 percent the proportion of people with high blood pressure who are taking action to help control their blood pressure. (Baseline: 79 percent of aware hypertensives aged 18 and older were taking action to control their blood pressure in 1985)

Special Population Targets

	<i>Taking Action to Control Blood Pressure</i>	<i>1985 Baseline</i>	<i>2000 Target</i>
15.5a	White hypertensive men aged 18–34	51% [†]	80%
15.5b	Black hypertensive men aged 18–34	63% [†]	80%

[†]Baseline for aware hypertensive men

Note: People with high blood pressure are defined in the National Health Interview Survey as those who are told on two or more occasions by a physician or other health professional that they had blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or taking antihypertensive medication. Actions to control blood pressure include taking medication, dieting to lose weight, cutting down on salt, and exercising.

15.6* Reduce the mean serum cholesterol level among adults to no more than 200 mg/dL. (Baseline: 213 mg/dL among people aged 20–74 in 1976–80, 211 mg/dL for men and 215 mg/dL for women)

15.7* Reduce the prevalence of blood cholesterol levels of 240 mg/dL or greater to no more than 20 percent among adults. (Baseline: 27 percent for people aged 20–74 in 1976–80, 29 percent for women and 25 percent for men)

15.8 Increase to at least 60 percent the proportion of adults with high blood cholesterol who are aware of their condition and are taking action to reduce their blood cholesterol to recommended levels. (Baseline: 30 percent of people with high blood cholesterol were aware that their blood cholesterol level was high in 1988)

Note: “High blood cholesterol” means a level that requires diet and, if necessary, drug treatment. Actions to control high blood cholesterol include keeping medical appointments, making recommended dietary changes (e.g., reducing saturated fat, total fat, and dietary cholesterol), and, if necessary, taking prescribed medication.

15.9* Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged 2 and older. (Baseline: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [CSFII]). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*’ average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of

less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 21 percent met the goal for fat and 21 percent met the goal for saturated fat based on 2-day dietary data from the 1989–91 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

15.10* Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 in 1976–80)

Special Population Targets

<i>Overweight Prevalence</i>	<i>1976–80 Baseline[†]</i>	<i>2000 Target</i>
15.10a Low-income women aged 20 and older	37%	25%
15.10b Black women aged 20 and older	44%	30%
15.10c Hispanic women aged 20 and older		25%
Mexican-American women	39% [‡]	
Cuban women	34% [‡]	
Puerto Rican women	37% [‡]	
15.10d American Indians/Alaska Natives	29–75% [§]	30%
15.10e People with disabilities	36% ^{††}	25%
15.10f Women with high blood pressure	50%	41%
15.10g Men with high blood pressure	39%	35%
15.10h Mexican-American men	30% [‡]	25%

[†]Baseline for people aged 20–74 [‡]1982–84 baseline for Hispanics aged 20–74 [§]1984–88 estimates for different tribes ^{††}1985 baseline for people aged 20–74 who report any limitation in activity due to chronic conditions derived from self-reported height and weight

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

15.11* Increase to at least 30 percent the proportion of people aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes 5 or more times per week and 16 percent were active 7 or more times per week in 1985)

Appendix A: 1995 Summary List of Objectives

Special Population Target

<i>Moderate Physical Activity</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
15.11a Hispanics 18 years and older 5 or more times per week	20%	25%

Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.

15.12* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older. (Baseline: 29 percent in 1987, 31 percent for men and 27 percent for women.)

Special Population Targets

<i>Cigarette Smoking Prevalence</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
15.12a People with a high school education or less aged 20 and older	34%	20%
15.12b Blue-collar workers aged 18 and older	41%	20%
15.12c Military personnel	42% [†]	20%
15.12d Blacks aged 18 and older	33%	18%
15.12e Hispanics aged 18 and older	24%	15%
15.12f American Indians/Alaska Natives	42–70% [‡]	20%
15.12g Southeast Asian men	55% [§]	20%
15.12h Women of reproductive age	29% ^{††}	12%
15.12i Pregnant women	25% ^{‡‡}	10%
15.12j Women who use oral contraceptives	36% ^{§§}	10%

[†]1988 baseline [‡]1979–87 estimates for different tribes [§]1984–88 baseline ^{††}Baseline for women aged 18–44 ^{‡‡}1985 baseline ^{§§}1983 baseline

Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes. Since 1992, estimates include some-day (intermittent) smokers.

Services and Protection Objectives

15.13 Increase to at least 90 percent the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high. (Baseline: 61 percent of people aged 18 and older had their blood pressure measured within the preceding 2 years and were given the systolic and diastolic values in 1985)

Note: A blood pressure measurement within the preceding 2 years refers to a measurement by a health professional or other trained observer.

Special Population Target

<i>Blood Pressure Checked</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
15.13a Mexican-American men	69%	90%

15.14 Increase to at least 75 percent the proportion of adults who have had their blood cholesterol checked within the preceding 5 years. (Baseline: 59 percent of people aged 18 and older had "ever" had their cholesterol checked in 1988; 52 percent were checked "within the preceding 2 years" in 1988)

Special Population Targets

<i>Blood Cholesterol Checked</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
<i>Ever checked</i>		
15.14a Blacks	56%	75%
15.14b Mexican Americans	42%	75%
15.14c American Indians/Alaska Natives	46%	75%
<i>Past two years</i>		
15.14d Mexican Americans	33%	75%
15.14e American Indians/Alaska Natives	38%	75%
15.14f Asians/Pacific Islanders	45%	75%

15.15 Increase to at least 75 percent the proportion of primary care providers who initiate diet and, if necessary, drug therapy at levels of blood cholesterol consistent with current management guidelines for patients with high blood cholesterol. (Baseline: Median cholesterol level, 240–259 mg/dL, when diet therapy is initiated; median cholesterol level, 300–319 mg/dL drug therapy is initiated.)

Note: Treatment recommendations at baseline are outlined in detail in the Report of the Expert Panel on the Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults, released by the National Cholesterol Education Program in 1987. Current treatment recommendations are described in the Second Report of the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults released in 1993. Treatment recommendations are likely to be refined over time. Thus, for the year 2000, "current" means whatever recommendations are then in effect.

15.16 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer high blood pressure and/or cholesterol education and control activities to their employees. (Baseline: 16.5 percent offered high blood pressure activities and 16.8 percent offered nutrition education activities in 1985; 35 percent offered high blood pressure and/or cholesterol programs in 1992)

15.17 Increase to at least 90 percent the proportion of clinical laboratories that meet the recommended accuracy standard for cholesterol measurement. (Baseline: 53 percent in 1985)

Cancer

Health Status Objectives

Note: In its publications, the National Cancer Institute age-adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for the health status objectives differ from those presented here.

16.1* Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people. (Age-adjusted baseline: 134 per 100,000 in 1987)

Special Population Target

	<i>Cancer Deaths (per 100,000)</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
16.1a Blacks		182	175

16.2* Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people. (Age-adjusted baseline: 38.5 per 100,000 in 1987)

Special Population Targets

	<i>Lung Cancer Deaths (per 100,000)</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
16.2a Females		25.6	27
16.2b Black males		86.1	91

16.3 Reduce breast cancer deaths to no more than 20.6 per 100,000 women. (Age-adjusted baseline: 23.0 per 100,000 in 1987)

Special Population Target

	<i>Breast Cancer Deaths (per 100,000)</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
16.3a Black females		27.5	25

16.4 Reduce deaths from cancer of the uterine cervix to no more than 1.3 per 100,000 women. (Age-adjusted baseline: 2.8 per 100,000 in 1987)

Special Population Targets

	<i>Cervical Cancer Deaths (per 100,000)</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
16.4a Black females		5.9	3
16.4b Hispanic females		3.6 [†]	2

[†]NIH, Surveillance, Epidemiology, and End Results (SEER) 1977–83, age-adjusted to 1940

16.5* Reduce colorectal cancer deaths to no more than 13.2 per 100,000 people. (Age-adjusted baseline: 14.7 per 100,000 in 1987)

Special Population Target

	<i>Colorectal Cancer Deaths (per 100,000)</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
16.5a Blacks		18.1	16.5

Risk Reduction Objectives

16.6* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older. (Baseline: 29 percent in 1987, 31 percent for men and 27 percent for women.)

Special Population Targets

	Cigarette Smoking Prevalence	1987 Baseline	2000 Target
16.6a	People with a high school education or less aged 20 and older	34%	20%
16.6b	Blue-collar workers aged 18 and older	41%	20%
16.6c	Military personnel	42% [†]	20%
16.6d	Blacks aged 18 and older	33%	18%
16.6e	Hispanics aged 18 and older	24%	15%
16.6f	American Indians/Alaska Natives	42–70% [‡]	20%
16.6g	Southeast Asian men	55% [§]	20%
16.6h	Women of reproductive age	29% ^{††}	12%
16.6i	Pregnant women	25% ^{‡‡}	10%
16.6j	Women who use oral contraceptives	36% ^{§§}	10%

[†]1988 baseline [‡]1979–87 estimates for different tribes [§]1984–88 baseline ^{††}Baseline for women aged 18–44 ^{‡‡}1985 baseline ^{§§}1983 baseline

Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes. Since 1992, estimates include same-day (intermittent) smokers.

16.7* Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged 2 and older. (Baseline: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [(CSFII)]. In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 21 percent met the goal for fat and 21 percent met the goal for saturated fat based on 2-day dietary data from the 1989–91 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

16.8* Increase complex carbohydrate and fiber-containing foods in the diets of people aged 2 and older to an average of 5 or more daily servings for vegetables (including legumes) and fruits, and to an average of 6 or more daily servings for grain products. (Baseline: 4.1 servings of vegetables and fruits and 5.8 servings of grain products for people aged 2 and older based on 3-day dietary data from the

1989–91 CSFII). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of 5 or more servings of vegetables/fruits, and increase to at least 50 percent the proportion who meet the goal of 6 or more servings of grain products. (Baseline: 29 percent met the goal for fruits and vegetables and 40 percent met the goal for grain products for people aged 2 and older based on 3-day dietary data in the 1989–91 CSFII).

Note: The definition of vegetables, fruits, and grain products and serving size designations are derived from The Food Guide Pyramid. Vegetable, fruit, and grain ingredients from mixtures are included in the total, and fractions of servings are counted.

Services and Protection Objectives

16.9 Increase to at least 60 percent the proportion of people of all ages who limit sun exposure, use sunscreens and protective clothing when exposed to sunlight, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths). (Baseline: 31 percent limited sun exposure, 28 percent used sunscreen, and 28 percent wore protective clothing in 1992)

16.10 Increase to at least 75 percent the proportion of primary care providers who routinely counsel patients about the following: tobacco use cessation, diet modification, and cancer screening recommendations, which includes providing information on the potential benefit or harm attributed to the various screening modalities and discussion of risk factors associated with breast, prostate, cervical, colorectal, and lung cancers. (Baseline: About 52 percent of internists reported counseling more than 75 percent of their smoking patients about smoking cessation in 1986)

16.11 Increase to at least 60 percent those women aged 50 and older who have received a clinical breast examination and a mammogram within the preceding 1–2 years. (Baseline: 25 percent of women aged 50 and older within the preceding 2 years in 1987)

Special Population Targets

<i>Clinical Breast Exam & Mammogram Received Within Preceding 2 Years:</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
16.11a Hispanic women aged 50 and older	18%	60%
16.11b Low-income women aged 50 and older (annual family income <\$10,000)	15%	60%
16.11c Women aged 50 and older with less than high school education	16%	60%
16.11d Women aged 70 and older	18%	60%
16.11e Black women aged 50 and older	19%	60%

16.12 Increase to at least 95 percent the proportion of women aged 18 and older who have ever received a Pap test, and to at least 85 percent those who received a Pap test within the preceding 1–3 years. (Baseline: 88 percent “ever” and 75 percent “within the preceding 3 years” in 1987)

Special Population Targets

<i>Pap Test: Ever Received</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
16.12a Hispanic women aged 18 and older	75%	95%
16.12b Women aged 70 and older	76%	95%
16.12c Women aged 18 and older with less than high school education	79%	95%
16.12d Low income women aged 18 and older (annual family income <\$10,000)	80%	95%
<i>Received Within Preceding 3 Years</i>		
16.12a Hispanic women aged 18 and older	66%	80%
16.12b Women aged 70 and older	44%	70%
16.12c Women aged 18 and older with less than high school education	58%	75%
16.12d Low income women aged 18 and older (annual family income <\$10,000)	64%	80%

16.13 Increase to at least 50 percent the proportion of people aged 50 and older who have received fecal occult blood testing within the preceding 1–2 years, and to at least 40 percent those who have ever received proctosigmoidoscopy. (Baseline: 27 percent received fecal occult blood testing during the preceding 2 years in 1987; 25 percent had ever received proctosigmoidoscopy in 1987)

16.14 Increase to at least 40 percent the proportion of people aged 50 and older visiting a primary care provider in the preceding year who have received oral, skin, and digital rectal examinations during one such visit. (Baseline: An estimated 27 percent received a digital rectal exam during a physician visit within the preceding year in 1987)

16.15 Ensure that Pap tests meet quality standards by monitoring and certifying all cytology laboratories. (Baseline data unavailable)

16.16 Ensure that mammograms meet quality standards by inspecting and certifying 100 percent according to the requirements of the Mammography Quality Standards Act. (Baseline: An estimated 18–21 percent certified by the American College of Radiology as of June 1990)

1995 Addition

Health Status Objective

16.17* Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline: 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

Special Population Targets

<i>Oral Cancer Deaths (per 100,000)</i>	<i>1990 Baseline</i>	<i>2000 Target</i>
16.17a Black males aged 45–74	29.4	26.0
16.17b Black females aged 45–74	6.9	6.9

Diabetes and Chronic Disabling Conditions

Health Status Objectives

17.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	1990 Baseline	2000 Target
17.1a	Blacks	56.0	60
17.1b	Hispanics	64.8	65
17.1c	People aged 65 and older	11.9 [†]	14 [†]

*Years of healthy life remaining at age 65

Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure.

17.2 Reduce to no more than 8 percent the proportion of people who experience a limitation in major activity due to chronic conditions. (Baseline: 9.4 percent in 1988)

Special Population Targets

	Prevalence of Disability	1988 Baseline	2000 Target
17.2a	Low-income people (annual family income <\$10,000 in 1988)	18.9%	15%
17.2b	American Indians/Alaska Natives	13.4% [†]	11%
17.2c	Blacks	11.2%	9%

[†]1983–85 baseline

	1991 Baseline	2000 Target
17.2d	Puerto Ricans	10%

Note: Major activity refers to the usual activity for one's age-gender group whether it is working, keeping house, going to school, or living independently. Chronic conditions are defined as conditions that either (1) were first noticed 3 or more months ago, or (2) belong to a group of conditions such as heart disease and diabetes, which are considered chronic regardless of when they began.

17.3 Reduce to no more than 90 per 1,000 people the proportion of all people aged 65 and older who have difficulty in performing two or more personal care activities, thereby preserving independence. (Baseline: 111 per 1,000 in 1984–85)

Special Population Targets

	Difficulty Performing Self-care Activities (per 1,000)	1984–85 Baseline	2000 Target
17.3a	People aged 85 and older	371	325
17.3b	Blacks aged 65 and older	112	98

Note: Personal care activities are bathing, dressing, using the toilet, getting in and out of bed or chair, and eating.

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17.4 Reduce to no more than 10 percent the proportion of people with asthma who experience activity limitation. (Baseline: Average of 19.4 percent during 1986–88)

Special Population Target

	<i>Asthmatics with Activity Limitations</i>	<i>1989–1991 Baseline</i>	<i>2000 Target</i>
17.4a	Blacks	30.5%	19%
17.4b	Puerto Ricans	51.5%	22%

Note: Activity limitation refers to any self-reported limitation in activity attributed to asthma.

17.5 Reduce activity limitation due to chronic back conditions to a prevalence of no more than 19 per 1,000 people. (Baseline: Average of 21.9 per 1,000 during 1986–88)

Note: Chronic back conditions include intervertebral disk disorders, curvature of the back or spine, and other self-reported chronic back impairments such as permanent stiffness or deformity of the back or repeated trouble with the back. Activity limitation refers to any self-reported limitation in activity attributed to a chronic back condition.

17.6 Reduce significant hearing impairment to a prevalence of no more than 82 per 1,000 people. (Baseline: Average of 88.9 per 1,000 during 1986–88)

Special Population Target

	<i>Hearing Impairment (per 1,000)</i>	<i>1986–88 Baseline</i>	<i>2000 Target</i>
17.6a	People aged 45 and older	203	180

Note: Hearing impairment covers the range of hearing deficits from mild loss in one ear to profound loss in both ears. Generally, inability to hear sounds at levels softer (less intense) than 20 decibels (dB) constitutes abnormal hearing. Significant hearing impairment is defined as having hearing thresholds for speech poorer than 25 dB. However, for this objective, self-reported hearing impairment (i.e., deafness in one or both ears or any trouble hearing in one or both ears) will be used as a proxy measure for significant hearing impairment.

17.7 Reduce significant visual impairment to a prevalence of no more than 30 per 1,000 people. (Baseline: Average of 34.5 per 1,000 during 1986–88)

Special Population Target

	<i>Visual Impairment (per 1,000)</i>	<i>1986–88 Baseline</i>	<i>2000 Target</i>
17.7a	People aged 65 and older	87.7	70

Note: Significant visual impairment is generally defined as a permanent reduction in visual acuity and/or field of vision which is not correctable with eyeglasses or contact lenses. Severe visual impairment is defined as inability to read ordinary newsprint even with corrective lenses. For this objective, self-reported blindness in one or both eyes and other self-reported visual impairments (i.e., any trouble seeing with one or both eyes even when wearing glasses or colorblindness) will be used as a proxy measure for significant visual impairment.

Appendix A: 1995 Summary List of Objectives

17.8* Reduce the prevalence of serious mental retardation among school-aged children to no more than 2 per 1,000 children. (Baseline: 2.7 per 1,000 children aged 10 in 1985–88)

Note: Serious mental retardation is defined as an Intelligence Quotient (I.Q.) less than 50. This includes individuals defined by the American Association of Mental Retardation as profoundly retarded (I.Q. of 20 or less), severely retarded (I.Q. of 21–35), and moderately retarded (I.Q. of 36–50).

17.9 Reduce diabetes-related deaths to no more than 34 per 100,000 people. (Age-adjusted baseline: 38 per 100,000 in 1986)

Special Population Targets

	<i>Diabetes-Related Deaths (per 100,000)</i>	<i>1986 Baseline</i>	<i>2000 Target</i>
17.9a Blacks		67.0	58
17.9b American Indians/Alaska Natives		46.0	41
		<i>1990 Baseline</i>	<i>2000 Target</i>
17.9c Mexican Americans		55.9	50
17.9d Puerto Ricans		47.0	42

Note: Diabetes-related deaths refer to deaths from diabetes as an underlying or contributing cause.

17.10 Reduce the most severe complications of diabetes as follows:

<i>Complications Among People With Diabetes</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
End-stage renal disease	1.5/1,000 [†]	1.4/1,000
Blindness	2.2/1,000	1.4/1,000
Lower extremity amputation	8.2/1,000 [†]	4.9/1,000
Perinatal mortality [‡]	5%	2%
Major congenital malformations [‡]	8%	4%

[†]1987 baseline [‡]Among infants of women with established diabetes

Special Population Targets for ESRD

	<i>ESRD Due to Diabetes (per 1,000)</i>	<i>1983–86 Baseline</i>	<i>2000 Target</i>
17.10a Blacks with diabetes		2.2	2.0
17.10b American Indians/Alaska Natives with diabetes		2.1	1.9

Special Population Target for Amputations

	<i>Lower Extremity Amputations Due to Diabetes (per 1,000)</i>	<i>1984–87 Baseline</i>	<i>2000 Target</i>
17.10c Blacks with diabetes		10.2	6.1

Note: End-stage renal disease (ESRD) is defined as requiring maintenance dialysis or transplantation and is limited to ESRD due to diabetes. Blindness refers to blindness due to diabetic eye disease.

17.11* Reduce diabetes to an incidence of no more than 2.5 per 1,000 people and a prevalence of no more than 25 per 1,000 people. (Baselines: 2.9 per 1,000 in 1987; 28 per 1,000 in 1987)

Special Population Targets

	<i>Prevalence of Diabetes (per 1,000) 1982–84 Baseline[†]</i>	<i>2000 Target</i>
17.11a American Indians/Alaska Natives	69 [‡]	62
17.11b Puerto Ricans	55	49
17.11c Mexican Americans	54	49
17.11d Cuban Americans	36	32
17.11e Blacks	36 [§]	32

[†]1982–84 baseline for people aged 20–74 [‡]1987 baseline for American Indians/Alaska Natives aged 15 and older [§]1987 baseline for blacks of all ages

Risk Reduction Objectives

17.12* Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 in 1976–80)

Special Population Targets

	<i>Overweight Prevalence 1976–80 Baseline[†]</i>	<i>2000 Target</i>
17.12a Low-income women aged 20 and older	37%	25%
17.12b Black women aged 20 and older	44%	30%
17.12c Hispanic women aged 20 and older		25%
Mexican-American women	39% [‡]	
Cuban women	34% [‡]	
Puerto Rican women	37% [‡]	
17.12d American Indians/Alaska Natives	29–75% [§]	30%
17.12e People with disabilities	36% [§]	25%
17.12f Women with high blood pressure	50%	41%
17.12g Men with high blood pressure	39%	35%
17.12h Mexican-American men	30% [‡]	25%

[†]Baseline for people aged 20–74 [‡]1982–84 baseline for Hispanics aged 20–74 [§]1984–88 estimates for different tribes [¶]1985 baseline for people aged 20–74 who report any limitation in activity due to chronic conditions derived from self-reported height and weight

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and

Appendix A: 1995 Summary List of Objectives

Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

17.13* Increase to at least 30 percent the proportion of people aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes five or more times per week, and 16 percent were active seven or more times per week in 1985)

Special Population Target

<i>Moderate Physical Activity</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
17.13a Hispanics 18 years and older five or more times per week	20%	25%

Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.

Services and Protection Objectives

17.14 Increase to at least 40 percent the proportion of people with chronic and disabling conditions who receive formal patient education including information about community and self-help resources as an integral part of the management of their condition. (Baseline data unavailable)

Type-Specific Targets

<i>Patient Education</i>	<i>1983–84 Baseline</i>	<i>2000 Target</i>
17.14a People with diabetes	32% (classes) 68% (counseling)	75%
17.14b People with asthma	9%	50%
17.14c Blacks with diabetes	34% (classes)	75%
17.14d Hispanics with diabetes	27% (classes)	75%

17.15 Increase to at least 80 percent the proportion of providers of primary care for children who routinely refer or screen infants and children for impairments of vision, hearing, speech and language, and assess other developmental milestones as part of well-child care. (Baseline: 19–72 percent of pediatricians, nurse practitioners, and family physicians reported routinely providing services to patients in 1992)

17.16 Reduce the average age at which children with significant hearing impairment are identified to no more than 12 months. (Baseline: Estimated as 24 to 30 months in 1988)

<i>Special Population Target</i>		
<i>Hearing Impairment</i>	<i>1991 Baseline</i>	<i>2000 Target</i>
17.16a Blacks	36	12

17.17 Increase to at least 60 percent the proportion of providers of primary care for older adults who routinely evaluate people aged 65 and older for urinary incontinence and impairments of vision, hearing, cognition, and functional status. (Baseline: 3–63 percent of nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

17.18 Increase to at least 90 percent the proportion of perimenopausal women who have been counseled about the benefits and risks of estrogen replacement therapy (combined with progestin, when appropriate) for prevention of osteoporosis. (Baseline data unavailable)

17.19 Increase to at least 75 percent the proportion of worksites with 50 or more employees that have a policy or program for the hiring of people with disabilities. (Baseline: 37 percent of medium and large companies in 1986)

Note: Mandated by the Americans with Disabilities Act.

17.20 Increase to 50 the number of States that have service systems for children with or at risk of chronic and disabling conditions, as required by Public Law 101-239. (Baseline data unavailable)

Note: Children with or at risk of chronic and disabling conditions, often referred to as children with special health care needs, include children with psychosocial as well as physical problems. This population encompasses children with a wide variety of actual or potential disabling conditions, including children with or at risk for cerebral palsy, mental retardation, sensory deprivation, developmental disabilities, spina bifida, hemophilia, other genetic disorders, and health-related educational and behavioral problems. Service systems for such children are organized networks of comprehensive, community-based, coordinated, and family-centered services.

1995 Additions

Health Status Objectives

17.21 Reduce the prevalence of peptic ulcer disease to no more than 18 per 1,000 people aged 18 and older by preventing its recurrence. (Baseline: 19.9 per 1,000 in 1991)

Source: National Health Interview Survey, CDC

Commentary:

The National Statistics of Peptic Ulcer Disease show that in the United States, gastrointestinal diseases lead all other conditions in office visits to physicians and are among the front-running causes for hospitalization. Digestive diseases cost the Nation more than \$50 billion annually and in chronic form effect about 37 million individuals. Of these, 11 percent—4 million patients, 19 years or older—are under treatment for peptic ulcer and have seen a physician during the past year. These patients account for most of the 2.1 million office visits per year for gastritis and duodenitis and 2.5 million office visits for abdominal pain. An additional 2.3 million individuals have had medically diagnosed ulcers within the past year but are not under active treatment at the moment. This totals about 6 million known peptic ulcer patients in a given year, each of whom, on the average, spend about 2 1/2 weeks under restricted activity (1 week of this in bed). About 240,000 patients are hospitalized each year with peptic ulcers. The average time of hospitalization is 1 week, amounting to a total of 1.7 million hospital days each year.

In the general population in the United States, the lifetime prevalence of peptic ulcer is 11 percent for men and 10 percent for women. The annual prevalence is 15 per 1,000 according to the 1991 National Health Interview Survey conducted by the CDC/National Center for Health Statistics.

Most peptic ulcers have a chronic, recurring course. The nature and severity of symptoms vary with their location, the patient's age, and other factors. Conventionally treated peptic ulcers usually heal but tend to recur (in most cases in intervals of between 10 and 18 months) and demand costly treatment for the lifetime of the patient. Some patients will have pain as the main presenting symptom; others report the presence of an ulcer for the first time when an acute complication—hemorrhage, gastrointestinal perforation, or obstruction develops. These are serious and may be life-threatening.

An effective new therapy now prevents the usual recurrence of the disease—the periodic development of new, active ulcers (“primary prevention”)—and the progressive generation of the serious, surgery-requiring complications (“secondary prevention”).

The costs of peptic ulcer disease to society are high in terms of human suffering as well as in direct and indirect economic costs. Among the direct costs are those related to these surgery, office and clinic visits, physician care, diagnostic tests, and significant expenditures for drugs. Indirect costs include loss of productivity due to absenteeism from work and loss of potential productivity due to premature death. Much of these costs and the considerable human suffering and disability have recently become avoidable.

In 1982, a bacterium, *Helicobacter pylori*, was cultured from the human stomach. Since then, it has been shown that this organism is associated with chronic gastritis and peptic ulcer disease. Data from throughout the world indicate that persistent infection with this organism accounts for the high recurrence rate and chronicity of peptic ulcer disease. New therapeutic regimens have been developed to eradicate the organism effectively in ulcer patients. These combination drug treatments, in addition to healing the acute ulcer, eradicate the organism and prevent ulcer recurrence and lifelong chronicity in the overwhelming majority of patients. With this new treatment, the potentially realizable cost saving in peptic ulcer care have been very conservatively estimated at \$760 million per year—an important, timely consideration. Under these new conditions, objectives calling for 1) reduced prevalence, 2) reduction of long-term complications of the disease, and 3) a diminution in direct and indirect cost to society are likely to show progress within a 10-year period.

17.22* Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline data unavailable)

Note: Disease prevention and health promotion data include disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.

Services and Protection Objective

17.23 Increase to 70 percent the proportion of people with diabetes who have an annual dilated eye exam. (Baseline: 49 percent for people aged 18 and older in 1989)

Source: Supplement to the National Health Interview Survey; Brechner, et al. JAMA, 1993.

Followup source: Supplement to the National Health Interview Survey and the Diabetes Supplement to the Behavioral Risk Factor Surveillance System.

Commentary:

Diabetes mellitus is the leading cause of blindness among working age Americans. Data indicate that approximately 90 percent of blindness due to diabetes could be prevented by secondary and tertiary prevention efforts. Regarding tertiary strategies, dilated eye exams are necessary to detect treatable retinopathy. It is recommended that by the year 2000 at least 70 percent of people with diabetes have an annual dilated eye exam by a qualified eye care specialist.

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HIV Infection

Health Status Objectives

18.1 Confine annual incidence of diagnosed AIDS cases to no more than 43 per 100,000 population. (Baseline: 17.0 per 100,000 in 1989)

	<i>Rates of AIDS Cases (per 100,000)</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
18.1a	Men who have sex with men (number of cases)	27,000	No more than 48,000
18.1b	Blacks	44.4	No more than 136 per 100,000
18.1c	Hispanics	34.9	No more than 76 per 100,000
18.1d	Women	3.5	No more than 13 per 100,000
18.1e	Injecting drug users (number of cases)	10,300	No more than 25,000

Note: Cases are by year of diagnosis and are corrected for delays in reporting and underreporting.

18.2 Confine the prevalence of HIV infection to no more than 400 per 100,000 people. (Baseline: An estimated 400 per 100,000 in 1989)

Special Population Targets

	<i>Estimated Prevalence of HIV Infection (per 100,000)</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
18.2a	Men who have sex with men	2,000–42,000 [†]	20,000
18.2b	Injecting drug users	30,000–40,000 [‡]	40,000
18.2c	Women giving birth to live infants	160	100

[†]Per 100,000 men who have sex with men aged 15–24 based on men tested in selected sexually transmitted disease clinics in unlinked surveys; most studies find HIV prevalence of between 2,000 and 21,000 per 100,000. [‡]Per 100,000 injecting drug users aged 15–24 in the New York City vicinity; in areas other than major metropolitan centers, infection rates in people entering selected drug treatment programs tested in unlinked surveys are often under 500 per 100,000.

Note: The year 2000 target has been revised to reflect new CDC estimates of the prevalence of HIV infection.

Risk Reduction Objectives

18.3* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline 27 percent of females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17; reported in 1988)

Appendix A: 1995 Summary List of Objectives

<i>Special Population Targets</i>			
	<i>Adolescents Engaged in Sexual Intercourse</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
18.3a	Black males aged 15	69%	15%
18.3b	Black males aged 17	90%	40%
18.3c	Black females aged 17	66%	40%

18.4* Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse. (Baseline: 19 percent of sexually active, unmarried women aged 15–44 reported that their partners used a condom at last sexual intercourse in 1988)

<i>Special Population Targets</i>			
	<i>Use of Condoms</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
18.4a	Sexually active young women aged 15–19 (by their partners)	26%	60%
18.4b	Sexually active young men aged 15–19	57%	75%
18.4c	Injecting drug users	34% [†]	75%
18.4d	Black women aged 15–44	12.4%	75%

[†] 1992 Baseline

18.5 Increase to at least 50 percent the estimated proportion of all injecting drug users who are in drug abuse treatment programs. (Baseline: An estimated 11 percent of opiate abusers were in treatment in 1989)

Note: An injecting drug user is anyone who within the past 12 months has injected drugs not prescribed by a physician. The definition of "drug abuse treatment" must include more than contact for treatment and must be sustained to be effective. Therefore, contacts for treatment do not represent treatment.

18.6 Increase to at least 75 percent the proportion of active injecting drug users who use only new or properly decontaminated syringes, needles and other drug paraphernalia ("works"). (Baseline: 30.8 percent in 1991)

18.7 Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection. (Baseline: 1 per 40,000 to 150,000 units in 1989)

Services and Protection Objectives

18.8 Increase to at least 80 percent the proportion of HIV-infected people who know their serostatus. (Baseline: 72.5 percent in 1990)

Note: This objective will be tracked by the percentage of positive tests at public counseling and testing sites to which people returned for posttest counseling.

18.9* Increase to at least 75 percent the proportion of primary care and mental health care providers who provide appropriate counseling[†] on the prevention of HIV and other sexually transmitted diseases. (Baseline: 10 percent of physicians reported that they regularly assessed the sexual behaviors of their patients in 1987)

Special Population Targets

<i>Counseling on HIV and STD Prevention</i>		<i>1987 Baseline</i>	<i>2000 Target</i>
18.9a	Providers practicing in high-incidence areas	—	90%
		<i>1992 Baseline</i>	<i>2000 Target</i>
18.9b	Family Physicians	27%	75%
18.9c	Internists	30%	75%
18.9d	Nurse Practitioners	50%	75%
18.9e	Obstetricians/gynecologists	46%	75%
18.9f	Pediatricians	46%	75%
18.9g	Mental Health Care Providers	—	75%

[†] Appropriate counseling is defined as counseling that is client centered and sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Primary care providers include physicians, nurses, nurse practitioners, and physician assistants. Mental health care providers include psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.

18.10* Increase to at least 95 percent the proportion of schools that provide appropriate[†] HIV and other STD education curricula for students in 4th–12th grade, preferably as part of comprehensive school health education, based upon scientific information that includes the way HIV and other STDs are prevented and transmitted. (Baseline: 95 percent of schools reported offering at least one class on sexually transmitted diseases as a part of their standard curricula in 1988)

[†] An appropriate curriculum is defined as one that is sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens. HIV and STD education should include information about primary transmission routes and should increase students' skills in avoiding infection.

18.11* Increase to at least 90 percent the proportion of students who received HIV and other STD information, education, or counseling on their college or university campus. (Baseline data unavailable)

18.12 Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact injecting drug users (particularly injecting drug users) to deliver HIV risk reduction messages. (Baseline: 35 percent in 1991)

Note: HIV risk reduction messages include messages about reducing or eliminating drug use, entering drug treatment, disinfection of injection equipment if still injecting drugs, and safer sex practices.

18.13* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that provide onsite primary prevention and provide or refer for secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

18.14 Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection. (Baseline: 100 percent in 1992)

1995 Additions

Risk Reduction Objective

18.15* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse for the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 and 33 percent of sexually active males aged 15–17 in 1988)

Commentary for shared objective:

The risks of early sexual intercourse include not only unwanted pregnancy, but also infection by sexually transmitted diseases, including HIV.

For young adolescents the most effective means of preventing possible physical and psychological problems related to sexual intercourse is to delay or stop sexual activity. But teenage sexual activity is a complex issue, embedded in family, social, and economic factors. Peers of the same gender are a major influence on adolescent attitudes about sexual activity. The proportion of their same sex peers that teenagers believe are sexually active and how sexually active they believe them to be are powerful predictors of sexual experience among adolescent boys and girls.

Young people who choose abstinence should be supported in this choice. Counselors and educators should be trained in building skills to help young people who choose abstinence to sustain their choice. Educational and counseling materials should give

credence and support to this choice and should promote virginity and abstinence as healthy choices. Peer groups advocating abstinence as an acceptable choice should be encouraged.

Interventions to prevent associated negative health outcomes from early sexual activity cannot be successful without the full support and involvement of parents and others who serve in advisory and role model capacities with teenagers.

Services and Protection Objectives

18.16 Increase to at least 50 percent the proportion of large businesses and to 10 percent the proportion of small businesses that implemented a comprehensive HIV/AIDS workplace program. (Baseline data unavailable)

<i>Comprehensive Programs</i>	<i>1995 Baseline</i>	<i>2000 Target</i>
Federal Government departments and agencies	80%	100%

Source: CDC

Note: An HIV/AIDS workplace program consists of (1) an HIV/AIDS written policy, (2) managerial training about the policy and its application and (3) HIV/AIDS employee education.

Commentary:

Workplace health promotion has long been seen as an effective activity to promote good health and prevent illness. The workplace provides access to an adult population at risk for many health problems and is an appropriate classroom for teaching employees how to reduce personal risk.

Seventy-six percent of AIDS cases are in people ages 25–44 and over 50 percent of the workforce is in this same age group. These workers are also the parents of the nation's youth where HIV infection is rapidly increasing: Employers provide a highly credible source of information to employees. Today's workplace offers access to people of every race, gender, sexual orientation, age, and ethnic group since all these segments of the population are found in the workplace.

In June 1993, the National Commission on AIDS recommended expansion of workplace education. On September 30, 1993, the President of the United States mandated HIV/AIDS education for all Federal employees providing leadership on this issue for the rest of the Nation's employers.

18.17 Increase to at least 40 percent the number of federally funded primary care clinics that have formal established linkages with substance abuse treatment programs and increase to at least 40 percent the number of federally funded substance abuse treatment programs that have formal established linkages with primary care clinics. (Baseline data unavailable)

Commentary:

In 1991, more than one-third of all AIDS cases were attributable to injecting drug use. AIDS cases in women are frequently correlated with both non-injecting drug and alcohol use and sex with injecting drug users.

Substance abuse treatment and primary health care have been historically separate systems of care that are now being forced together because of HIV-related disease. To meet the needs of substance-involved individuals, coordination and integration of specialized substance abuse services with the primary health care, mental health, and HIV/AIDS service systems are needed at State and local levels in both the public and private sectors. Access to an integrated array of general and specialized health and social services will promote better treatment outcomes and sustained recovery for injecting and non-injecting drug users and provide the best strategy for lowering the rates of HIV transmission within the drug-using community.

Sexually Transmitted Diseases

Health Status Objectives

19.1 Reduce gonorrhea to an incidence of no more than 100 cases per 100,000 people. (Baseline: 300 per 100,000 in 1989)

Special Population Targets

	<i>Gonorrhea Incidence (per 100,000)</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
19.1a	Blacks	1,990	650
19.1b	Adolescents aged 15–19	1,123	375
19.1c	Women aged 15–44	501	175

19.2 Reduce the prevalence of *Chlamydia trachomatis* infections among young women (under the age of 25 years) to no more than 5 percent. (Baseline: 8.5 percent in women 20–24 and 12.2 percent in females 19 and younger in 1988)

Note: As measured by a decrease in the prevalence of chlamydia infection among family planning clients <25 years old at their initial visit.

19.3 Reduce primary and secondary syphilis to an incidence of no more than 4 cases per 100,000 people. (Baseline: 18.1 per 100,000 in 1989)

Special Population Target

	<i>Primary and Secondary Syphilis Incidence (per 100,000)</i>	<i>1989 Baseline</i>	<i>2000 Target</i>
19.3a	Blacks	118	30

19.4 Reduce congenital syphilis to an incidence of no more than 40 cases per 100,000 live births. (Baseline: 91.0 per 100,000 live births in 1990)

Special Population Targets

	<i>Congenital syphilis (per 100,000)</i>	<i>1992 Baseline</i>	<i>2000 Target</i>
19.4a	Blacks	427	175
19.4b	Hispanics	135	50

19.5 Reduce genital herpes and genital warts, as measured by a reduction to 138,500 and 246,500, respectively, in the annual number of first-time consultations with a physician for the conditions. (Baseline: 163,000 and 290,000 in 1988)

19.6 Reduce the incidence of pelvic inflammatory disease, as measured by a reduction in hospitalizations for pelvic inflammatory disease to no more than 100 per 100,000 women aged 15–44 and a reduction in the number of initial visits to physicians for pelvic inflammatory disease to no more than 290,000. (Baseline: 311 per 100,000 in 1988 and 430,800 visits in 1988)

Special Population Targets

	<i>Hospitalizations for PID (per 100,000)</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
19.6a	Blacks	655	150
19.6b	Adolescents (aged 15–19)	342	110

Appendix A: 1995 Summary List of Objectives

19.7[†] Reduce sexually transmitted hepatitis B infection to no more than 30,500 cases. (Baseline: 47,593 cases in 1987)

19.8 Reduce the rate of repeat gonorrhea^a infection to no more than 15 percent within the previous year. (Baseline: 20 percent in 1987)

Note: As measured by a reduction in the proportion of gonorrhea patients who, within the previous year, were treated for a separate case of gonorrhea.

Special Population Target

	<i>Repeat Gonorrhea</i>	<i>1992 Baseline</i>	<i>2000 Target</i>
19.8a	Blacks [†]	21.3%	17%

[†]Proportion of male gonorrhea patients with one or more gonorrhea infections within the previous 12 months.

Risk Reduction Objectives

19.9* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17 reported in 1988)

Special Population Targets

	<i>Adolescents Engaged In Sexual Interconrse</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
19.9a	Black males aged 15	69%	15%
19.9b	Black males aged 17	90%	40%
19.9c	Black females aged 17	66%	40%

19.10* Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse. (Baseline: 19 percent of sexually active, unmarried women aged 15–44 reported that their partners used a condom at last sexual intercourse in 1988)

Special Population Targets

	<i>Use of Condoms</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
19.10a	Sexually active young women aged 15–19 (by their partners)	26.0%	60%
19.10b	Sexually active young men aged 15–19	57.0%	75%
19.10c	Injecting drug users	34.0% [†]	75%
19.10d	Black women aged 15–44	12.4%	75%

[†] 1992 Baseline

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.

Services and Protection Objectives

19.11* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that provide onsite primary and secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

19.12* Increase to at least 95 percent the proportion of schools that provide appropriate[†] HIV and other STD education curricula for students in 4th–12th grade, preferably as part of comprehensive school health education, based upon scientific information that includes the way HIV infection and other STDs are prevented and transmitted. (Baseline: 95 percent of schools reported offering at least one class on sexually transmitted diseases as part of their standard curricula in 1988)

* An appropriate curriculum is defined as one that is sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens. HIV and STD education should include information about primary transmission routes and should increase students' skills in avoiding infection.

19.13 Increase to at least 90 percent the proportion of primary care providers treating patients with sexually transmitted diseases who correctly manage cases, as measured by their use of appropriate types and amounts of therapy. (Baseline: 70 percent in 1988)

19.14* Increase to at least 75 percent the proportion of primary care and mental health care providers who provide appropriate counseling[†] on the prevention of HIV and other sexually transmitted diseases. (Baseline: 10 percent of physicians reported that they regularly assessed the sexual behaviors of their patients in 1987)

Special Population Targets

<i>Counseling on HIV and STD Prevention</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
19.14a Providers practicing in high-incidence areas	—	90%
	<i>1992 Baseline</i>	<i>2000 Target</i>
19.14b Family Physicians	27%	75%
19.14c Internists	30%	75%
19.14d Nurse Practitioners	50%	75%
19.14e Obstetricians/gynecologists	46%	75%
19.14f Pediatricians	46%	75%
19.14g Mental Health Care Providers	—	75%

[†] Appropriate counseling is defined as counseling that is client centered and sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Primary care providers include physicians, nurses, nurse practitioners and physician assistants. Mental health care providers include psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.

19.15 Increase to at least 50 percent the proportion of all patients with bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) who are offered provider referral services. (Baseline: 20 percent of those treated in sexually transmitted disease clinics in 1988)

Note: Provider referral (previously called contact tracing) is the process whereby health department personnel directly notify the sexual partners of infected individuals of their exposure to an infected individual for the purpose of education, counseling, and referral to health care services.

1995 Additions

Risk Reduction Objective

19.16* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse for the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 in 1988; 33 percent of sexually active males aged 15–17 in 1988)

Services and Protection Objective

19.17* Increase to at least 90 percent the proportion of students who received HIV and other STD information, education, or counseling on their college or university campus. (Baseline data unavailable)

Immunization and Infectious Diseases

Health Status Objectives

20.1 Reduce indigenous cases of vaccine-preventable diseases as follows:

<i>Disease</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
Diphtheria among people aged 25 and younger	1	0
Tetanus among people aged 25 and younger	3	0
Polio (wild-type virus)	0	0
Measles	3,058	0
Rubella	225	0
Congenital Rubella Syndrome	6	0
Mumps	4,866	500
Pertussis	3,450	1,000

20.2 Reduce epidemic-related pneumonia and influenza deaths among people aged 65 and older to no more than 15.9 per 100,000. (Baseline: Average of 19.9 per 100,000 during 1979–1987. This represents the average of the eight seasons from the 1979–80 season through the 1986–87 season.)

Note: Epidemic-related pneumonia and influenza deaths are those that occur above and beyond the normal yearly fluctuations of mortality. Because of the extreme variability in epidemic-related deaths from year to year, it will be measured using a 3-year average.

20.3 Reduce viral hepatitis as follows:

<i>(Per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
Hepatitis B	63.5	40.0
Hepatitis A	33.0	16.0
Hepatitis C	18.3	13.7

Special Population Targets

	<i>Hepatitis B (Number of Cases)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
20.3a	Injecting drug users	44,348	7,932
20.3b	Heterosexually active people	33,995	22,663
20.3c	Homosexual men	13,598	4,568
20.3d	Children of Asians/Pacific Islanders	10,817	1,500
20.3e	Occupationally exposed workers	3,090	623
20.3f	Infants (chronic infections)	6,012	1,111
20.3g	Alaska Natives (number of new carriers)	15	1
		<i>1992 Baseline</i>	<i>2000 Target</i>
20.3h	Blacks (cases per 100,000)	52.8	40
	<i>Hepatitis A (cases per 100,000)</i>		
20.3i	Hispanics	53.8	27
20.3j	American Indians/Alaska Natives	256.0	128
	<i>Hepatitis C (cases per 100,000)</i>		
20.3k	Hispanics	17.2	13

Appendix A: 1995 Summary List of Objectives

20.4 Reduce tuberculosis to an incidence of no more than 3.5 cases per 100,000 people. (Baseline: 9.1 per 100,000 in 1988)

Special Population Targets

	<i>Tuberculosis Cases (per 100,000)</i>	<i>1988 Baseline</i>	<i>2000 Target</i>
20.4a	Asians/Pacific Islanders	36.3	15
20.4b	Blacks	28.3	10
20.4c	Hispanics	18.3	5
20.4d	American Indians/Alaska Natives	18.1	5

20.5 Reduce by at least 10 percent the incidence of surgical wound infections and nosocomial infections in intensive care patients. (Baseline: Device-associated nosocomial infection rates (per 1,000 device days for bloodstream infections, urinary tract infections and pneumonia in medical/coronary ICUs, surgical/medical-surgical ICUs and pediatric ICUs in 1986–90 and surgical wound infection rates (per 100 operations), low-risk patients 1.1, medium low-risk patients 3.2, medium-high-risk patients 6.3, and high-risk patients 14.4 in 1986–90)

20.6 Reduce selected illness among international travelers as follows:

<i>Number of Cases</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
Typhoid fever	280	140
Hepatitis A	4,475	1,119
Malaria	932	750

20.7 Reduce bacterial meningitis to no more than 4.7 cases per 100,000 people. (Baseline: 6.5 per 100,000 in 1986)

Special Population Target

	<i>Bacterial Meningitis Cases (per 100,000)</i>	<i>1987 Baseline</i>	<i>2000 Target</i>
20.7a	Alaska Natives	33	8

20.8 Reduce infectious diarrhea by at least 25 percent among children in licensed child care centers and children in programs that provide an Individualized Education Program (IEP) or Individualized Health Plan (IHP). (Baseline: 32 percent in children aged 0 to 6 years and 38 percent in children aged 0 to 3 years in 1991)

20.9 Reduce acute middle ear infections among children aged 4 and younger, as measured by days of restricted activity or school absenteeism, to no more than 105 days per 100 children. (Baseline: 135.4 days per 100 children in 1987)

20.10 Reduce pneumonia-related days of restricted activity as follows:

	<i>1987 Baseline</i>	<i>2000 Target</i>
People aged 65 and older (per 100 people)	19.1 days	15.1 days
Children aged 4 and younger (per 100 children)	29.4 days	24 days

Risk Reduction Objectives

20.11 Increase immunization levels as follows: Basic immunization series among children through age 2: at least 90 percent. (Baseline: revised to 54 to 64 percent in 1985)

Basic immunization series among children in licensed child care facilities and kindergarten through postsecondary education institutions: at least 95 percent. (Baseline: For licensed child care, 94–95 percent; 97–98 percent for children entering school for the 1987–1988 school year; and for postsecondary institutions, baseline data unavailable in 1992)

Hepatitis B immunization among high-risk populations, including infants of hepatitis B surface antigen-positive mothers to at least 90 percent; occupationally exposed workers to at least 90 percent; injecting drug users in drug treatment programs to at least 50 percent; and men who have sex with men to at least 50 percent. (Baseline: 40 percent of infants of surface antigen-positive mothers in 1991; 37 percent of occupationally exposed workers in 1989; and data are unavailable for injecting drug users and men who have sex with men)

Pneumococcal pneumonia and influenza immunization among institutionalized chronically ill or older people: at least 80 percent. (Baseline data unavailable)

Pneumococcal pneumonia and influenza immunization among noninstitutionalized, high-risk populations, as defined by the Immunization Practices Advisory Committee: at least 60 percent. (Baseline: 14 percent estimated for pneumococcal vaccine and 30 percent for influenza vaccine in 1989)

Special Population Targets

<i>Percent Immunized</i>	<i>Influenza Vaccines</i>	<i>Pneumococcal Vaccines</i>	<i>2000 Target</i>
	<i>1991 Baseline</i>	<i>1991 Baseline</i>	
20.11a Blacks 65 years and older	27%	14%	60%
20.11b Hispanics 65 years and older	34%	12%	60%

20.12 Reduce postexposure rabies treatments to no more than 9,000 per year. (Baseline: 18,000 estimated treatments in 1987)

Services and Protection Objectives

20.13 Expand immunization laws for schools, preschools, and day care settings to all States for all antigens. (Baseline: 10–49 States and the District of Columbia depending on the antigen and setting in 1989)

20.14 Increase to at least 90 percent the proportion of primary care providers who provide information and counseling about immunizations and offer immunizations as appropriate for their patients. (Baseline: 68–89 percent of pediatricians, nurse practitioners, and family physicians reported routinely providing immunization services to children; and 4–49 percent of nurse practitioners, obstetricians/gynecologists, internists and family physicians reported routinely providing immunization services to adult patients in 1992)

20.15 Improve the financing and delivery of immunizations for children and adults so that virtually no American has a financial barrier to receiving recommended immunizations. (Baseline: Financial coverage for immunizations was included in 45 percent of employment-based insurance plans with conventional insurance plans; 62 percent with Preferred Provider Organization plans; and 98 percent with Health Maintenance Organization plans in 1989; Medicaid covered basic immunizations for eligible children, and Medicare covered pneumococcal immunization for eligible older adults in 1981 and influenza immunization in 1993)

20.16 Increase to at least 90 percent the proportion of public health departments that provide adult immunization for influenza, pneumococcal disease, hepatitis B, tetanus, and diphtheria. (Baseline: 37 to 70 percent in 1990)

20.17 Increase to at least 90 percent the proportion of local health departments that have ongoing programs for actively identifying cases of tuberculosis and latent infection in populations at high risk for tuberculosis. (Baseline data unavailable)

Note: Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.

20.18 Increase to at least 85 percent the proportion of people found to have tuberculosis infection who completed courses of preventive therapy. (Baseline: 89 health departments reported that 66.3 percent of 95,201 persons placed on preventive therapy completed their treatment in 1987)

20.19 Increase to at least 85 percent the proportion of tertiary care hospital laboratories and to at least 50 percent the proportion of secondary care hospital and health maintenance organization laboratories possessing technologies for rapid viral diagnosis of influenza. (Baseline: 52 percent of tertiary care hospitals; 45 percent of secondary care hospitals, and 69 percent of HMOs in 1993)

Clinical Preventive Services

Health Status Objective

21.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	1990 Baseline	2000 Target
21.1a	Blacks	56	60
21.1b	Hispanics	64.8	65
21.1c	People aged 65 and older	11.9 [†]	14 [†]

[†]Years of healthy life remaining at age 65

Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure.

Risk Reduction Objective

21.2 Increase the proportion of people who have received selected clinical preventive screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force.

Receipt of Selected Clinical Preventive and Counseling Services

Special and Type-Specific Targets

	1991 Baseline	2000 Target
Basic Immunization Series (4 DTP, 3 Polio, and 2 MMR)	55% [‡]	90%
Children 19–35 months:		
DTP (3 or more doses)	83% [‡]	
Polio (3 or more doses)	72% [‡]	
Measles/Mumps/Rubella (1 dose)	83% [‡]	
Haemophilus influenzae B (3 or more doses)	28% [‡]	
Hepatitis B (1 dose)	16% [§]	

Special Population Targets

	1991 Baseline	2000 Target
Routine check-up [†]	74%	91%
People 65 years and over	67%	
Cholesterol checked in last 5 years [*]	60% [§]	75%
Cholesterol ever checked [*]	63%	75%
Low-income people	46%	
Blacks [*]	56%	
Hispanics	51%	
American Indians/Alaska Natives [*]	46%	

Appendix A: 1995 Summary List of Objectives

	1991 Baseline	2000 Target
<i>Cholesterol checked in last 2 years</i>	50%	75%
Low-income people	37%	
Hispanics	42%	
Asians/Pacific Islanders	45%	
American Indians/Alaska Natives	38%	
<i>Tetanus booster in last 10 years</i>	52%	62%
People 65 years and over	29%	
Hispanics	45%	
Asians/Pacific Islanders	40%	
People with disabilities	47%	
<i>Pneumococcal vaccine in lifetime (Aged 65 and over)</i>	21%	60%
Low-income people	17%	
Blacks*	14%	
Hispanics*	12%	
Asians/Pacific Islanders	15%	
<i>Influenza vaccine in last year (Aged 65 and over)*</i>	42%	60%
Low-income people	36%	
Blacks*	27%	
Hispanics*	34%	
Asians/Pacific Islanders	29%	
<i>Pap test in last 3 years</i>		
Women aged 18 and over	74% [‡]	85%
Women aged 65 and over	51% [‡]	
Asians/Pacific Islanders	62% [‡]	
American Indians/Alaska Natives	64% [‡]	
Women with disabilities	65% [‡]	
<i>Breast exam and mammogram in past 2 years</i>		
Women 50 years and over	51% [‡]	60%
Women aged 65 and over	43% [‡]	
Low-income women	30% [‡]	
Asians/Pacific Islanders	38% [‡]	
American Indians/Alaska Natives	31% [‡]	
Women with disabilities	44% [‡]	
<i>Counseling services^{††}</i>	56%	80%
People aged 65 and over	42%	
Asians/Pacific Islanders	51%	

Note: Baselines and targets for total population (18 years and over); special populations have more than a 10 percent disparity with the total population.

[†]In the last 3 years for people aged 18–64 and in the last year for people aged 65 and older [‡]1992 data [§]1993 data ^{††}For people aged 18–64, counseling is defined as a screening question on at least one of the following: diet, physical activity, tobacco use, alcohol use, drug use, sexually transmitted diseases, contraceptive use in the past 3 years. For people aged 65 and over, counseling on at least one of: diet, physical activity, tobacco use, alcohol use in the past year.

Services and Protection Objectives

21.3 Increase to at least 95 percent the proportion of people who have a specific source of ongoing primary care for coordination of their preventive and episodic health care. (Baseline: 80 percent in 1991)

Special Population Targets

	Percentage With Source of Care	1991 Baseline	2000 Target
21.3a	Hispanics	63%	95%
	Mexican Americans	57%	95%
21.3b	Blacks	78%	95%
21.3c	Low-income people	71%	95%
21.3d	American Indians/Alaska Natives	70%	95%
21.3e	Asians/Pacific Islanders	70%	95%

Note: Since 1991, the emergency room has not been counted as a regular source for primary care services. 21.3a breaks out only Mexican Americans since the rates for Puerto Ricans and Cubans are similar to the total population.

21.4 Improve financing and delivery of clinical preventive services so that virtually no American has a financial barrier to receiving, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline: 16 percent of people aged 65 and under in 1989)

Special Population Targets

	Proportion of People Without Health Care Coverage (People Under 65 Years)	1989 Baseline	2000 Target
21.4a	American Indians/Alaska Natives	36%	0%
21.4b	Hispanics	31%	0%
	Mexican Americans	38%	0%
	Puerto Ricans	21%	0%
	Cubans	21%	0%
21.4c	Blacks	22%	0%

21.5 Ensure that at least 90 percent of people for whom primary care services are provided directly by publicly funded programs are offered, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline: 10–100 percent for screening recommendations; 40–100 percent for counseling recommendations; 10–96 percent for immunizations in 1991–92)

Note: Publicly funded programs that provide primary care services directly include federally funded programs such as the Maternal and Child Health Program, Community and Migrant Health Centers, and the Indian Health Service as well as primary care service settings funded by State and local governments. This objective does not include services covered indirectly through the Medicare and Medicaid programs.

21.6 Increase to at least 50 percent the proportion of primary care providers who provide their patients with the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline: 4–96 percent of pediatricians, nurse practitioners, family physicians, internists, and obstetricians/gynecologists reported routinely providing recommended services to patients in 1992)

21.7 Increase to at least 90 percent the proportion of people who are served by a local health department that assesses and assures access to essential clinical preventive services. (Baseline: proportion of local health departments that assess the extent to which clinical preventive services are provided in jurisdiction—76 percent; proportion of local health departments that collect data to document the number of providers of clinical preventive services—45 percent; proportion of local health departments that evaluate the availability of and need for clinical preventive services—57 percent; of these, the proportion that provide programs to fill gaps—83 percent in 1992)

Note: Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.

21.8 Increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to members of underrepresented racial and ethnic minority groups as follows:

<i>Degrees Awarded To</i>	<i>1985–86 Baseline</i>	<i>2000 Target</i>
Blacks	5%	8.0%
Hispanics	3%	6.4%
American Indians/Alaska Natives	0.3%	0.6%

Note: Underrepresented minorities are those groups consistently below parity in most health profession schools—blacks, Hispanics, and American Indians and Alaska Natives.

21.8a Increase the proportion of individuals from underrepresented racial and ethnic minority groups enrolled in U.S. schools of nursing.

<i>Proportion Enrolled in fall Academic Year*</i>	<i>1991–92 Baseline</i>	<i>2000 Target</i>
Blacks	9.1%	10%
Hispanic	3.1%	4%
Asians/Pacific Islanders [†]	2.9%	5%
American Indians/Alaska Natives	0.7%	1%

*Enrollment figures have been shown to be statistically predictive of graduating rates.

[†]The Asians/Pacific Islanders special population target is important because at this time the majority of Asian/Pacific Islander nurses in the United States is foreign-educated. Since this subobjective refers to preparing nurses in this country, it is appropriate to consider these nurses as an underrepresented minority.

Surveillance and Data Systems

Health Status Objectives

22.1 Develop a set of health status indicators appropriate for Federal, State, and local health agencies and establish use of the set in at least 40 States. (Baseline: Set developed in 1991)

22.2 Identify, and create where necessary, national data sources to measure progress toward each of the year 2000 national health objectives. (Baseline: 77 percent of the objectives have baseline data in 1990)

Type-Specific Target

	1995 Baseline	2000 Target
22.2a Identify, and create where necessary, State level data for at least two-thirds of the objectives in State year 2000 plans	42 States	50 States

22.3 Develop and disseminate among Federal, State, and local agencies procedures for collecting comparable data for each of the year 2000 national health objectives and incorporate these into Public Health Service data collection systems. (Baseline: 12 percent of objectives in 1990)

22.4* Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline data unavailable)

Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.

22.5 Implement in all States periodic analysis and publication of data needed to measure progress toward objectives for at least 10 of the priority areas of the national health objectives. (Baseline: 20 States reported that they disseminate the analyses they use to assess State progress toward the health objectives to the public and to health professionals in 1989)

Type-Specific Target

	1992 Baseline	2000 Target
22.5a Periodic analysis and publication of State progress toward the national or State-specific objectives for each racial or ethnic group that makes up at least 10 percent of the State population	19 States	50 States

Note: Periodic is at least once every 4 years. Objectives include, at a minimum, one from each objectives category: health status, risk reduction, and services and protection.

22.6 Expand in all States systems for the transfer of health information related to the national health objectives among Federal, State, and local agencies. (Baseline: 30 States reported that they have some capability for transfer of health data, tables, graphs, and maps to Federal, State, and local agencies that collect and analyze data in 1989)

Note: Information related to the national health objectives includes State and national level baseline data, disease prevention/health promotion evaluation results, and data generated to measure progress.

22.7 Achieve timely release of national surveillance and survey data needed by health professionals and agencies to measure progress toward the national health objectives. (Baseline: 65 percent of data released within 1 year of collection and 24 percent of data were released between 1 and 2 years of collection in 1994)

Note: Timely release (publication of provisional or final data or public use data tapes) should be based on the use of the data, but is at least within 1 year of the end of data collection.

Age-Related Objectives

*Reduce the death rate for children by 15 percent to no more than 28.6 per 100,000 children aged 1–14, and for infants by approximately 30 percent to no more than 7 per 1,000 live births. (Baseline: 33.7 per 100,000 for children in 1987 and 10.1 per 1,000 live births for infants in 1987)

Reduce the death rate for adolescents and young adults by 15 percent to no more than 83.1 per 100,000 people aged 15–24. (Baseline: 97.8 per 100,000 in 1987)

Reduce the death rate for adults by 20 percent to no more than 341.5 per 100,000 people aged 25–64. (Baseline: 426.9 per 100,000 in 1987)

*Reduce to no more than 90 per 1,000 people the proportion of all people aged 65 and older who have difficulty in performing two or more personal care activities (a reduction of about 19 percent), thereby preserving independence. (Baseline: 111 per 1,000 in 1984–85)

APPENDIX B

History of the Objectives Development and the Midcourse Revisions Process

The year 2000 objectives build upon an effort, initiated in 1979 with the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* and established in 1980 with the publication of *Promoting Health/Preventing Disease: Objectives for the Nation*. Adopting a management-by-objectives planning process familiar to the world of business, the U.S. Public Health Service (PHS) set out objectives addressing improvements in health status, risk reduction, public and professional awareness of prevention, health services and protective measures, and surveillance and evaluation, expressed in terms of measurable targets to be accomplished by 1990. These objectives were organized in 15 priority areas under the general headings of preventive services, health protection, and health promotion. In 1985, an interim assessment resulted in the publication of *The 1990 Health Objectives for the Nation: A Midcourse Review*. The following year, a steering committee was formed within PHS to oversee the process of revising the objectives to target the year 2000.

The approach taken in developing year 2000 objectives paralleled the 1990 objectives in the comprehensiveness of the issues addressed. To broaden participation in the year 2000 objectives development effort, the Assistant Secretary for Health invited 157 national membership organizations and all the State and Territorial health departments to join PHS in a national consortium. In addition, PHS established a partnership with the Institute of Medicine, National Academy of Sciences to convene a series of regional hearings across the country. Using the input and expert review of over 7,000 individuals and groups, the PHS Steering Committee defined 22 priority areas to serve as the initial framework for drafting year 2000 objectives.

The year 2000 priority areas expand upon those of the 1990 objectives, with the addition of areas focused on topics such as HIV infection and cancer. In addition, the year 2000 objectives are characterized by an increased emphasis on prevention of disability and morbidity; greater attention to improvements in the health status of definable population groups at highest risk of premature death, disease, and disability; and inclusion of more screening interventions to detect asymptomatic diseases and conditions early enough to prevent premature death or chronic illness.

Within PHS, there are lead agencies for each priority area. The 1995 revisions were developed by the lead PHS agencies. New objectives for the year 2000, new special population targets, modifications to the year 2000 targets, and revisions to language in selected objectives were coordinated and edited by the Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, which has been designated by the Assistant Secretary as the coordinating office for this process.

In developing the year 2000 objectives and the 1995 midcourse revisions, lead agencies were guided by eight criteria. They are:

- *Credibility*—Objectives should be realistic and should address the issues of greatest priority.

- *Public comprehension*—Objectives should be understandable and relevant to a broad audience, including those who plan, manage, deliver, use, and pay for health services.
- *Balance*—Objectives should be a mixture of outcome and process measures, recommending methods for achieving changes and setting standards for evaluating progress.
- *Measurability*—Objectives should be quantified.
- *Continuity*—Year 2000 objectives should be linked to the 1990 objectives where possible but reflect the lessons learned in implementing them.
- *Compatibility*—Objectives should be compatible where possible with goals already adopted by Federal agencies and health organizations.
- *Freedom from data constraints*—The availability or form of data should not be the principal determinant of the nature of the objectives. Alternate and proxy data should be used where necessary.
- *Responsibility*—The objectives should reflect the concerns and engage the participation of professionals, advocates, and consumers as well as State and local health departments.

The year 2000 objectives are organized broadly into three major sections that identify the principal type of preventive intervention they involve: Health Promotion, Health Protection, and Clinical Preventive Services. The 22 priority areas have been retained. *The numbers do not indicate a rank ordering of priorities.* In each priority area (with the exception of Surveillance and Data Systems), objectives are organized by three types:

- *Health Status* - targets to reduce death, disease, and disability and to enhance functional status, including physical, mental, and social functioning and well-being as well as general perception of health and satisfaction.
- *Risk Reduction* - targets to reduce the prevalence or incidence of risks to health or to increase behaviors known to reduce such risks.
- *Services and Protection* - targets to increase comprehensiveness, accessibility, and/or quality of preventive services and protective interventions.

On October 3, 1994, proposed midcourse revisions were published in the *Federal Register* for public review and comment. There were no changes proposed to the three goals of HEALTHY PEOPLE 2000 or to the organization of the 22 priority areas. Proposed were:

- new objectives that reflect scientific developments and new information that has become available;
- revisions to published objectives to encompass current issues and data reporting systems;
- new special population targets to focus on groups that are of highest risk of premature death, disease, or disability; and
- revisions to year 2000 targets where the baseline has changed.

A recurring theme in the development and review process conducted to date has been the focus on the needs of those population groups that are at highest risk for premature death, disease, or disability. Consequently, the year 2000 revisions proposal contained more than 100 proposed special population targets. In each case, targets were only offered if the population in question—whether an age group, a minority group, people with disabilities, or people with low incomes—had demonstrated higher risk or was more vulnerable to the subject disease or condition than the population as a whole. It should be noted that data were not available on all possible population groups that may have been at higher risk than the general population.

These special population targets have been set using three criteria: 1) They should be *realistic* and thus may not be the same as targets set for the population as a whole, which starts at a better baseline. 2) They should be *challenging* and thus should call for greater proportional improvements than the general population targets. 3) The targets for special population groups must seek to *close the gap* between the special population and the total population.

More than 550 public comments were received on the proposed midcourse revisions. Those public comments were used by the lead PHS agencies to finalize the Summary List of Objectives published in Appendix A of this document.

APPENDIX C

Contributors to the *Healthy People 2000* *Midcourse Review*

Healthy People 2000 Midcourse Review and 1995 Revisions

Healthy People 2000: Midcourse Review and 1995 Revisions is the product of a national effort that has involved professionals and citizens, private organizations, and public agencies from every part of the Nation.

Preparation of the report was sponsored by the U.S. Public Health Service (PHS), through a project coordinated by the Deputy Assistant Secretary for Health (Disease Prevention and Health Promotion). Project management was facilitated by the work of the PHS Steering Committee on HEALTHY PEOPLE 2000. Principal staff and editorial responsibility for the project was carried out by James A. Harrell and Deborah Maiese. Other staff from the Office of Disease Prevention and Health Promotion helping in the coordination and development of the overall project included Ashley Files, Debra Rothstein, Lisa Kane, Valerie Welsh, Adam Borah, Marilyn K. Schulenberg, Juan Washington, David Baker, Janice Radak, and Peter Lindeman. The Public Health Foundation worked with the States in the development of the Consortium Action chapter.

While it is not possible to recognize herein all those citizens and officials who made contributions to *Healthy People 2000*, their efforts were central to the development of the final product.

Public Health Service Office Directors and Agency Heads

Philip R. Lee, Assistant Secretary for Health, Washington, DC
Jo Ivey Boufford, Principal Deputy Assistant Secretary for Health, Washington, DC
Audrey F. Manley, Acting Surgeon General, Washington, DC
Susan Blumenthal, Deputy Assistant Secretary for Women's Health, Washington, DC
William Corr, Deputy Assistant Secretary for Health, Washington, DC
Martis J. Davis, Deputy Assistant Secretary for Health (Communications),
Washington, DC
Anthony F. Fitzpatrick, Director, Office of Intergovernmental Affairs, Rockville, MD
Eric Goosby, Director, Office of HIV/AIDS Policy, Washington, DC
D. A. Henderson, Senior Science Advisor, Washington, DC
Anthony L. Itteilag, Deputy Assistant Secretary for Health Management Operations,
Washington, DC
Roz Lasker, Deputy Assistant Secretary for Health Policy, Washington, DC
J. Michael McGinnis, Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion), Washington DC
Sandra Perlmutter, Executive Director, President's Council on Physical Fitness
and Sports, Washington, DC
Clay E. Simpson, Deputy Assistant Secretary for Minority Health,
Rockville, MD
Felicia Stewart, Deputy Assistant Secretary for Health (Population Affairs),
Washington, DC

Susanne Stoiber, Acting Deputy Assistant Secretary for Disease Prevention and Health Promotion/Health Policy and Evaluation, Washington, DC
Robert O. Valdez, Deputy Assistant Secretary for Health, Washington, DC
Linda A. Vogel, Acting Deputy Assistant Secretary for International and Refugee Health, Rockville, MD

Agency Heads

Clifton R. Gaus, Administrator, Agency for Health Care Policy and Research, Rockville, MD
David Satcher, Director, Centers for Disease Control and Prevention (CDC), Atlanta, GA
David A. Kessler, Commissioner, Food and Drug Administration (FDA), Rockville, MD
Ciro V. Sumaya, Administrator, Health Resources and Services Administration (HRSA), Rockville, MD
Michael H. Trujillo, Director, Indian Health Service (IHS), Rockville, MD
Harold E. Varmus, Director, National Institutes of Health (NIH), Rockville, MD
Nelba R. Chavez, Administrator, Substance Abuse and Mental Health Services Administration, Rockville, MD

Public Health Service Steering Committee on the HEALTHY PEOPLE 2000 Objectives

PHS Members, by Agency

James A. Harrell, *Chair*, Office of Disease Prevention and Health Promotion, Washington, DC
Ronald H. Carlson, Health Resources and Services Administration, Rockville, MD
Jack Feldman and Mary Anne Freedman, National Center for Health Statistics, CDC, Hyattsville, MD
Margaret M. Gilliam, Substance Abuse and Mental Health Services Administration, Rockville, MD
William R. Harlan, National Institutes of Health, Bethesda, MD
John T. Kalberer, Jr., National Institutes of Health, Bethesda, MD
Evelyn Kappeler, Office of Population Affairs, Bethesda, MD
Martha F. Katz, Office of Program Planning and Evaluation, CDC, Atlanta, GA
Audrey Manley, formerly Office of Minority Health, Acting Surgeon General, Washington, DC
Peter Rheinstein, Food and Drug Administration, Rockville, MD
Raymond Seltser, Agency for Health Policy and Research, Rockville, MD
Christine G. Spain, President's Council on Physical Fitness and Sports, Washington, DC
Craig Vanderwagen, Indian Health Service, Rockville, MD

Coordinators of Priority Area Working Groups

Physical Activity and Fitness

Christine G. Spain, President's Council on Physical Fitness and Sports,
Washington, DC

Carl Casperson, National Center for Chronic Disease Prevention and
Health Promotion, CDC, Atlanta, GA

Nutrition

Van Hubbard, National Institute of Diabetes and Digestive and Kidney Diseases,
NIH, Bethesda, MD

Christine Lewis and Nancy Crane, Center for Food Safety and Applied Nutrition,
FDA, Washington, DC

Tobacco

Michelle Chang, Office on Smoking and Health, National Center for Chronic
Disease Prevention and Health Promotion, CDC, Atlanta, GA

Julie Fishman, Office on Smoking and Health, National Center for Chronic Disease
Prevention and Health Promotion, CDC, Atlanta, GA

Substance Abuse: Alcohol and Other Drugs

Ann Mahony, Substance Abuse and Mental Health Services Administration,
Rockville, MD

Family Planning

Evelyn Kappeler, Office of Population Affairs, Bethesda, MD

Mental Health and Mental Disorders

Maury Lieberman, Substance Abuse and Mental Health Services Administration,
Rockville, MD

Juan Ramos, National Institute of Mental Health, NIH, Bethesda, MD

Violent and Abusive Behavior

Mark Long, National Center for Injury Prevention and Control, CDC, Atlanta, GA

Martha Highsmith, National Center for Injury Prevention and Control, CDC,
Atlanta, GA

Educational and Community-Based Programs

Brick Lancaster, National Centers for Chronic Disease Prevention and Health
Promotion, CDC, Atlanta, GA

Ronald H. Carlson, Health Resources and Services Administration, Rockville, MD

Unintentional Injuries

LaTanya Beale, National Center for Injury Control and Prevention, CDC,
Atlanta, GA

Occupational Safety and Health

Ann Cronin, National Institute for Occupational Safety and Health, CDC,
Atlanta, GA

Environmental Health

Daniel Vandermeer, National Institute of Environmental Health Sciences, NIH,
Research Triangle Park, NC

Henry Falk, National Center for Environmental Health, CDC, Atlanta, GA

Food and Drug Safety

Peter Rheinstein, Food and Drug Administration, Rockville, MD

J. David Wolfson, Food and Drug Administration, Rockville, MD

Oral Health

Helen Gift, National Institute of Dental Research, NIH, Bethesda, MD

Dolores Malvitz, National Center for Preventive Services, CDC, Atlanta, GA

Maternal and Infant Health

Stella Yu, Maternal and Child Health Bureau, HRSA, Rockville, MD

Heart Disease and Stroke

Claude L'Enfant, National Heart, Lung, and Blood Institute, NIH, Bethesda, MD

Gregory J. Morosco, National Heart, Lung, and Blood Institute, NIH, Bethesda, MD

Cancer

Ed Sondik, National Cancer Institute, NIH, Bethesda, MD

Barry Portnoy, National Cancer Institute, NIH, Bethesda, MD

Judith Swan, National Cancer Institute, NIH, Bethesda, MD

Diabetes and Chronic Disabling Conditions

Benjamin Burton, National Institute of Diabetes and Digestive and Kidney Diseases,
NIH, Bethesda, MD

Frank M. Vinicor, National Center for Chronic Disease Prevention and Health
Promotion, CDC, Atlanta, GA

HIV Infection

Jo Messore, Office of HIV/AIDS Policy, Office of the Assistant Secretary for Health,
Washington, DC

Sexually Transmitted Diseases

Joel Greenspan, National Center for Prevention Services, CDC, Atlanta, GA

Immunization and Infectious Diseases

Walter Orenstein, National Immunization Program, CDC, Atlanta, GA

James Hughes, National Center for Infectious Diseases, CDC, Atlanta, GA

Clinical Preventive Services

Ronald H. Carlson, HRSA, Rockville, MD

Alan R. Hinman, National Center for Prevention Services, CDC, Atlanta GA

Surveillance and Data Systems

Jack Feldman, National Center for Health Statistics, CDC, Hyattsville, MD

Mary Anne Freedman, National Center for Health Statistics, CDC, Hyattsville, MD

Richard Klein, National Center for Health Statistics, CDC, Hyattsville, MD

Kathleen Turczyn, National Center for Health Statistics, CDC, Hyattsville, MD

Susan Schober, National Center for Health Statistics, CDC, Hyattsville, MD

Fred Seitz, National Center for Health Statistics, CDC, Hyattsville, MD

Christine Plepys, National Center for Health Statistics, CDC, Hyattsville, MD

APPENDIX D

HEALTHY PEOPLE 2000 Consortium

ORGANIZATIONS

Academy of General Dentistry
ACLI-HIAA Center for Corporate Public Involvement
Aerobics and Fitness Association of America
Alcohol and Drug Problems Association
Alliance for Aging Research
Amateur Athletic Union of the United States
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Nursing
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology, Head and Neck Surgery
American Academy of Pain Management
American Academy of Pediatric Dentistry
American Academy of Pediatrics
American Alliance for Health, Physical Education, Recreation and Dance
American Art Therapy Association
American Association for Clinical Chemistry
American Association for Dental Research
American Association for Marriage and Family Therapy
American Association for Respiratory Care
American Association for the Advancement of Science
American Association of Certified Orthoptists
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Dental Schools
American Association of Homes for the Aging
American Association of Occupational Health Nurses
American Association of Pathologists' Assistants
American Association of Public Health Dentistry
American Association of Public Health Physicians
American Association of Retired Persons
American Association of School Administrators
American Association of Suicidology
American Association of University Affiliated Programs
American Association on Mental Retardation
American Cancer Society
American College Health Association
American College of Cardiology
American College of Clinical Pharmacy
American College of Gastroenterology
American College of Health Care Administrators
American College of Health Care Executives

American College of Nurse-Midwives
American College of Nutrition
American College of Obstetricians and Gynecologists
American College of Occupational and Environmental Medicine
American College of Physicians
American College of Preventive Medicine
American College of Radiology
American College of Sports Medicine
American Correctional Health Services Association
American Council on Alcoholism
American Council on Exercise
American Counseling Association
American Dental Association
American Dental Hygienists' Association
American Diabetes Association
American Dietetic Association
American Federation of Teachers
American Fund for Dental Health
American Geriatrics Society
American Heart Association
American Home Economics Association
American Hospital Association
American Indian Health Care Association
American Institute for Preventive Medicine
American Institute of Nutrition
American Kinesitherapy Association
American Liver Foundation
American Lung Association
American Meat Institute
American Medical Association
American Medical Student Association
American Nurses Association
American Occupational Therapy Association
American Optometric Association
American Orthopaedic Society for Sports Medicine
American Osteopathic Academy of Sports Medicine
American Osteopathic Association
American Osteopathic Health Care Association
American Pharmaceutical Association
American Physical Therapy Association
American Physiological Society
American Podiatric Medical Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association

American Public Health Association
American Red Cross
American Rehabilitation Counseling Association
American Running and Fitness Association
American School Food Service Association
American School Health Association
American Social Health Association
American Society for Clinical Nutrition
American Society for Gastrointestinal Endoscopy
American Society for Health Care Marketing and Public Relations
American Society for Microbiology
American Society for Parenteral and Enteral Nutrition
American Society for Pharmacology and Experimental Therapeutics
American Society of Acupuncture
American Society of Addiction Medicine
American Society of Hospital Pharmacists
American Society of Human Genetics
American Society of Ocularists
American Speech-Language-Hearing Association
American Spinal Injury Association
American Statistical Association
American Thoracic Society
American Trauma Society
American Veterinary Medical Association
Aquatic Exercise Association
Arthritis Foundation
Asian and Pacific Islander American Health Forum
Asociacion Nacional Pro Personas Mayores
ASPO/Lamaze Association
Association for Applied Psychophysiology and Biofeedback
Association for Hospital Medical Education
Association for Practitioners in Infection Control
Association for Vital Records and Health Statistics
Association for Worksite Health Promotion
Association for the Advancement of Automotive Medicine
Association for the Advancement of Health Education
Association for the Care of Children's Health
Association of Academic Health Centers
Association of American Indian Physicians
Association of American Medical Colleges
Association of Clinical Scientists
Association of Community Health Nursing Educators
Association of Food and Drug Officials
Association of Maternal and Child Health Programs
Association of Occupational and Environmental Clinics

Association of Pediatric Oncology Nurses
Association of Rehabilitation Nurses
Association of Schools of Allied Health Professions
Association of Schools of Public Health
Association of State and Territorial Dental Directors
Association of State and Territorial Directors of Nursing
Association of State and Territorial Directors of Public Health Education
Association of State and Territorial Health Officials
Association of State and Territorial Public Health Laboratory Directors
Association of State and Territorial Public Health Nutrition Directors
Association of State and Territorial Public Health Social Work
Association of Teachers of Preventive Medicine
Association of Technical Personnel in Ophthalmology
Association of Women's Health, Obstetric and Neonatal Nurses
Asthma and Allergy Foundation of America
Black Congress on Health, Law and Economics
Blue Cross and Blue Shield Association
Boy Scouts of America
Business Roundtable
Camp Fire
Cardiovascular Credentialing International
Catholic Health Association of the United States
Center to Prevent Handgun Violence
Chamber of Commerce of the United States of America
Coalition for Consumer Health and Safety
College of American Pathologists
Consortium of Social Science Associations
Council for Responsible Nutrition
Council of Medical Specialty Societies
Emergency Nurses Association
Employee Assistance Professionals Association
Eye Bank Association of America
Federation of American Societies for Experimental Biology
Federation of Behavioral, Psychological, and Cognitive Sciences
Federation of Nurses and Health Professionals
Food Marketing Institute
Future Homemakers of America
General Federation of Women's Clubs
Gerontological Society of America
Girl Scouts of the U.S.A.
Grocery Manufacturers of America
Group Health Association of America
Health Industry Manufacturers Association
Health Insurance Association of America
Health Ministries Association

Health Sciences Communications Association
Healthier People Network
Healthy Mothers, Healthy Babies
Highway Users Federation for Safety and Mobility
Institute of Food Technologists
International Health, Racquet and Sportsclub Association
International Hearing Society
International Lactation Consultant Association
International Life Sciences Institute
International Patient Education Council
La Leche League International
Learning Disabilities Association of America
March of Dimes Birth Defects Foundation
Maternal and Child Health Net-Link
Maternity Center Association
Midwives Alliance of North America
Migrant Clinicians Network
Mothers Against Drunk Driving
National 4-H Council/Extension Service
National Alliance for the Mentally Ill
National Alliance of Black School Educators
National Alliance of Nurse Practitioners
National Alliance of Senior Citizens
National Asian and Pacific American Families Against Substance Abuse
National Association for Family and Community Education
National Association for Home Care
National Association for Human Development
National Association for Music Therapy
National Association for Public Worksite Health Promotion
National Association for Sport and Physical Education
National Association of Biology Teachers
National Association of Childbearing Centers
National Association of Children's Hospitals and Related Institutions
National Association of Community Health Centers
National Association of County and City Health Officials
National Association of Elementary School Principals
National Association of Governor's Councils on Physical Fitness and Sports
National Association of Neighborhoods
National Association of Neonatal Nurses
National Association of Optometrists and Opticians
National Association of Pediatric Nurse Associates and Practitioners
National Association of Rehabilitation Facilities
National Association of Retail Druggists
National Association of RSVP Directors
National Association of School Nurses

National Association of Secondary School Principals
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Association of State Boards of Education
National Association of State Nutrition Education and Training Coordinators
National Association of State School Nurse Consultants
National Athletic Trainers' Association
National Black Nurses Association
National Board of Medical Examiners
National Center for Health Education
National Center for Policy Coordination in Maternal and Child Health
National Civic League
National Coalition Against Sexual Assault
National Coalition of Hispanic Health and Human Services Organizations
National Commission Against Drunk Driving
National Committee for Prevention of Child Abuse
National Conference of State Legislatures
National Consumers League
National Council for International Health
National Council for the Education of Health Professionals in Health Promotion
National Council of Community Hospitals
National Council on Adoption
National Council on Alcoholism and Drug Dependence
National Council on Health Laboratory Services
National Council on Patient Information and Education
National Council on the Aging
National Dairy Council
National Environmental Health Association
National Family Planning and Reproductive Health Association
National Federation for Specialty Nursing Organizations
National Federation of State High School Associations
National Food Processors Association
National Head Injury Foundation
National Health Council
National Health Lawyers Association
National Hispanic Council on Aging
National Institute for Fitness and Sports
National Kidney Foundation
National Leadership Coalition on AIDS
National League for Nursing
National Lesbian and Gay Health Foundation
National Medical Association
National Mental Health Association
National Migrant Resource Program
National Minority AIDS Council

National Minority Health Association
National Nurses Society on Addictions
National Organization for Women
National Organization on Adolescent Pregnancy, Parenting and Prevention
National Osteoporosis Foundation
National Parent/Teachers Association
National Pediculosis Association
National Pest Control Association
National Pressure Ulcer Advisory Panel
National Prevention Coalition
National Recreation and Park Association
National Restaurant Association
National SAFE Kids Campaign
National Safety Council
National School Boards Association
National Society of Allied Health
National Society to Prevent Blindness
National Strength and Conditioning Association
National Stroke Association
National Wellness Institute
National Women's Health Network
Network of Employers for Traffic Safety
North American Association for the Study of Obesity
Nursing Network on Violence Against Women
Oncology Nursing Society
Opticians Association of America
Paralyzed Veterans of America
Partnership for Prevention
People's Medical Society
Pharmaceutical Manufacturers Association
Physicians for a Violence-Free Society
Planned Parenthood Federation of America
Poison Prevention Week Council
Population Association of America
Produce for Better Health Foundation
Produce Marketing Association
Road Runners Club of America
Salt Institute
Salvation Army
Sex Information and Education Council of the United States
Society for Adolescent Medicine
Society for Hospital Epidemiology of America
Society for Nutrition Education
Society for Public Health Education
Society of Behavioral Medicine

Society of General Internal Medicine
Society of Preventive Medicine
Society of Prospective Medicine
Society of State Directors of Health, Physical Education and Recreation
State Family Planning Administrators
Sugar Association
The Arc
Think First Foundation
Unitarian Universalist Seventh Principle Project
United States Conference of Local Health Officers
United States Conference of Mayors
United States Eye Injury Registry
United Way of America
Visiting Nurse Association of America
Voluntary Hospitals of America
Washington Business Group on Health
Wellness Councils of America
Western Consortium for Public Health
Women's Sports Foundation
Wound, Ostomy and Continence Nurses Society
YMCA of the USA

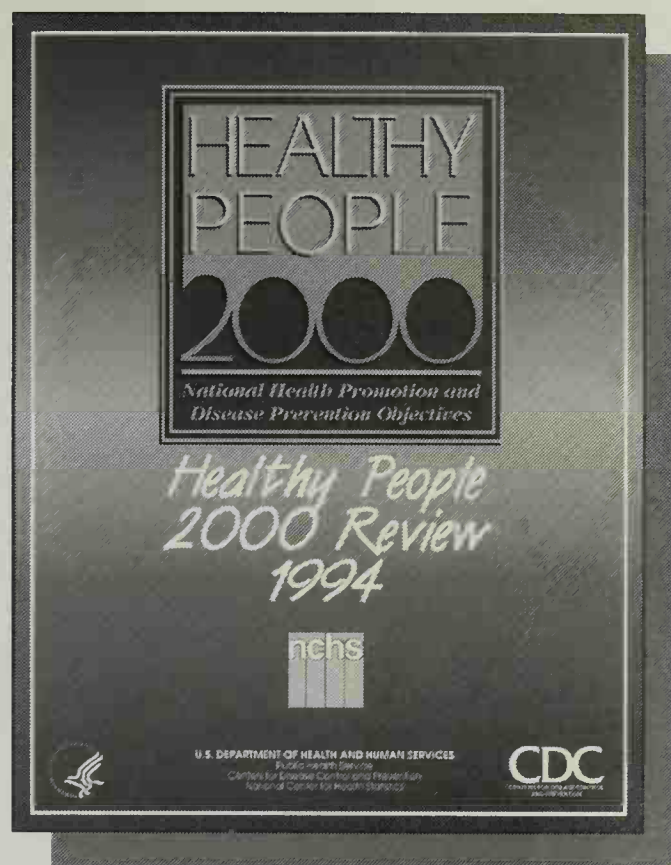
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California Department of Health Services
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Guam Department of Public Health and Social Services
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Illinois Department of Public Health
Indiana State Board of Health
Iowa Department of Public Health
Kansas Department of Health
Kentucky Department for Health Services
Louisiana Department of Health and Hospitals

Maine Bureau of Health
Maryland Health Resources Planning Commission
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Michigan Department of Health
Minnesota Department of Health
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*The annual report
on the national
year 2000 objectives...*

Healthy People 2000 Review, 1994



The National Center for Health Statistics has released the third annual overview of progress toward the *Healthy People 2000* objectives. *Healthy People 2000* is a national program designed to meet the national health promotion and disease prevention objectives by the year 2000. The program also identifies special subobjectives for groups at greater health risk

or those medically underserved. This comprehensive report presents up-to-date tables, graphics, and narratives describing progress towards the national year 2000 targets. This report will be useful to analysts, educators, researchers, and others concerned with health at the local, state, and national levels.



Publication Order Form

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National Center for Health Statistics
6525 Belcrest Road, Room 1064
Hyattsville, Maryland 20782



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